Medicare Claims Processing Manual

Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims

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(Rev. 831, 02-02-06)
(Rev. 900, 04-07-06)

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10 - Electronic Data Interchange (EDI) General Outreach Activities

(Rev. 615, Issued: 07-22-05, Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and Fiscal Intermediaries (FIs) are to actively encourage providers to increase their use of EDI transactions. Also see § 60 of this Chapter. Specific outreach requirements are included in the CMS requirements for implementation of new or (Revised EDI standards. Carriers, DMERCs and FIs are also required to notify providers about the need to file most claims with Medicare electronically (see §90). In general, carriers, DMERCs, and FIs must:

- Feature information on EDI during trade shows, vendor fairs, educational forums, and vendor association meetings that they sponsor or in which they participate;

- Provide educational information on EDI to providers identified in internal analysis described in §10.1 as well as to the software vendors and clearinghouses that serve or market services to Medicare providers;

- Make themselves available whenever possible, and invited to participate as an EDI speaker on the agenda of organized provider group meetings, such as state or local chapters of AAHAM, HFMA, MGMA, EDI user groups, state and local medical societies, and other provider and related vendor trade groups. DMERCs shall participate in regional meetings that entail supplier use of EDI; and

- Include specific and meaningful EDI messages in provider newsletters, addressing the themes described in §10.3 below, other issues that may be pertinent to the carrier, DMERC, or FI's geographic area, and as directed in individual EDI instructions issued by CMS. Carriers, DMERCs, and FIs are expected to point out the advantages to providers in the use of EDI transactions.

See the Medicare Beneficiary and Providers Communication Manual (100-09) for definitive guidance on Medicare's provider outreach requirements. Provider outreach activities, including those that involve EDI are funded through the Provider Education and Training budget issued to Medicare contractors. This EDI-specific information is included in this chapter as a reminder to the Medicare contractors.

10.1 – Carrier, DMERC, and FI Analysis of Internal Information

(Rev. 615, Issued: 07-22-05, Effective/Implementation Dates: 10-01-05)

10.1.1 - Systems Information

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Shared system maintainers must prepare quarterly reports for the carriers, DMERCs, and FIs that list each provider's name, provider number, address, number of paper claims received under each provider number, the percentage of all claims submitted on paper by

each provider, and the period for which data is being reported. The first report is due for the period July through September, 2005, and must be issued to the users of each shared system in October, 2005. The reports must be arrayed by provider in decreasing volume order (from highest to lowest) of paper claims. (See § 90.5 of this chapter for use of these reports for Administrative Simplification Compliance Act [ASCA] enforcement).

Carriers, DMERCs, and FIs may share this information with vendors who market EDI services to providers, and may charge vendors for costs they incur to distribute this information. No personally identifiable beneficiary data or sensitive provider data, such as social security numbers, taxpayer identifications numbers, or annual income from Medicare payments, may be included in the records shared with these vendors. As permitted by their provider outreach budget, and as required and budgeted under §90 of this chapter for ASCA enforcement (Reviews, carriers, DMERCs, and FIs must contact providers with the highest number of paper claim transactions to have them begin submission of claims electronically. Carriers, DMERCs, and FIs are also to strongly encourage providers to conduct their claims status, beneficiary eligibility, payment and remittance advice transactions electronically.

Efforts to increase use of EDI must be documented to p(Revent duplicate contacts, to provide a basis for future discussions with those providers, and to substantiate those instances where the provider refuses to submit claims or other transactions electronically. Systems information may also identify specific markets, e.g., specialties, to target for EDI campaigns.

Recognizing that this process, from initial contact to implementation, may span a varying duration of time, staff must be able to judge, from the provider's cues, when to intensify activities and when to withdraw for a period of time. Carriers, DMERCs and FIs are expected to use professional sales techniques:

- Know their EDI products;
- Know their customer's business;
- Question and listen to determine customer needs and interest;
- Use demonstrations;
- Create interest and overcome objections;
- Prove the benefits of EDI; and
- Successfully resolve issues if appropriate to enable use.

Also, carriers, DMERCs, and FIs must identify providers that have previously committed to use EDI but have not begun transition within an appropriate period, e.g., 30 days after successful EMC testing is completed, for follow-up to determine the reason for delay.

10.2 - Contact With New Providers

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs must conduct an analysis of the capability of each provider (including physicians and suppliers) that contact a Medicare contractor to begin submission of Medicare claims, or for DMERCs, when notified by the National Supplier

Clearinghouse that new supplier identification numbers have been issued. EDI transactions are to be presented as the normal mode of business for Medicare claims, claim status, remittance, and EFT as the normal mode for funds transfer. See Chapter 31 for information on eligibility verification queries. Where the provider does not have the related capability, carriers, DMERCs, and FIs are to inform the providers of available options to begin use of EDI, e.g., list of vendors and clearinghouses and billing services, availability of Medicare's free software.

Carriers, DMERCs, and FIs should make EDI materials available to newly enrolled providers, and carriers and FIs (not DMERCs) are encouraged to work with local medical schools where possible to introduce EDI to medical students by:

- Conducting EDI seminars for medical students;
- Demonstrating Medicare's free software;
- Extending invitations to vendor trade fairs; and
- Distributing EDI literature.

10.3 - Production and Distribution of Information to Increase Use of EDI

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs are required to post information on their provider web page to educate and influence providers in all aspects of EDI. They must include the following information at a minimum:

- Earlier payment of electronic claims that comply with Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification standards requirements;
- The benefit of earlier detection of errors via edits conducted upon submission of electronic transactions;
- The relative ease of use of EDI and the support available from the contractor to assist them in beginning use of EDI transactions;
- Advantages of online correction of errors (FIs only);
- Lower administrative, postage, and handling costs;
- Electronic adjustments (FIs only);
- Availability of free software; and
- Availability of batch claims status inquiries.

- The information must be updated on a regular basis. Carriers, DMERCs, and FIs are encouraged to issue these materials via the Internet or E-Mail when possible, but paper copies may be distributed where most cost effective or when a provider may not have Internet or E-Mail access.

10.4 - Production and Distribution of Material to Market EDI

(Rev. 1, 10-01-03)

B3-3023.7, AB-01-19

Carriers and FIs are required to produce and distribute material to educate and influence providers in all aspects of EDI.

They must include the following themes in published material:

- Earlier payment of claims because of different payment floor requirements;
- The benefit of earlier detection of errors via edits;
- The relative ease of EDI and support available;
- Advantages of online correction of errors (FIs only);
- Lower administrative, postage, and handling costs;
- Electronic adjustments (FIs only);
- Availability of free software;
- Claims status inquiry; and
- Eligibility query.

They must include in written materials testimonials and/or case studies from providers and facilities that have benefited from using EDI transactions.

These materials may be produced in-house or by local printing companies. The contents must be maintained up to date. Therefore, carriers and FIs must carefully plan print quantities to match planned distribution to avoid unnecessary waste.

They must make the material available to staff that have contact with the provider community and make arrangements for distribution at trade shows and seminars that the carrier or FI does not attend as well as those that they do attend.

20 - EDI Enrollment

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs are required to furnish new providers that request Medicare claim privileges information on EDI. DMERCs are to furnish such information to new providers when contacted by providers, or by the National Supplier Clearinghouse to identify new suppliers that have been issued new identifiers. Carriers and FIs are required to assess the capability of entities to submit data electronically, establish their qualifications (see test requirements in §50), and enroll and assign submitter EDI identification numbers to those approved to use EDI.

When providers contact a contractor to submit/receive transactions electronically using a billing agent or a clearinghouse/network services vendor, carriers, DMERCs, FIs, or any other contractors as designated by CMS must notify those providers that they are required to have an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. (These agreements are not to be submitted to Medicare, but are to be retained by the providers.) The providers must also be informed that they are not permitted to share their personal EDI access number and password with any billing agent, clearinghouse/network service vendor; to anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim; and that no other non-staff individuals or entities may be permitted to use a provider's EDI number and password to access Medicare systems. Clearinghouse and other third party representatives must obtain and use their own unique EDI access number and password from those Medicare contractors to whom they will send or from whom they will receive EDI transactions.

A provider's EDI number and password serve as a provider's electronic signature and the provider would be liable if any entity with which the provider improperly shared the ID and password performed an illegal action while using that ID and password. A provider's EDI access number and password are not part of the capital property of the provider's operation, and may not be given to a new owner of the provider's operation. A new owner must obtain their own EDI access number and password.

20.1 - EDI Enrollment Form

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

A3-3601.4, B3-3021.4

20.1.1 - New Enrollments and Maintenance of Existing Enrollments

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

The Medicare EDI Enrollment process provides for collection of the information needed to successfully exchange EDI transactions between Medicare and EDI trading partners and also establishes the expectations for both parties in the exchange. This agreement must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party. Each provider that will use EDI either directly or

through a billing agent or clearinghouse to exchange EDI transactions with Medicare must sign the EDI Enrollment Form and submit it to the carrier, DMERC, or FI with which EDI transactions will be exchanged before the carrier, DMERC, or FI will accept production claims or other incoming EDI transactions from that provider, or a third party for that provider, or send outbound EDI transactions. Carriers, DMERCs, and FIs may accept a signed EDI Enrollment Form from providers via fax or hard copy. The EDI Enrollment Form is effective as specified in the terms of the agreement.

NOTES:

1. Although a type of electronic transaction, electronic funds transfers (EFTs) between a carrier, DMERC, or FI and a bank are not considered EDI for EDI Enrollment Form purposes. A provider that uses EFT but no EDI transactions should not complete an EDI Enrollment Form.

2. Medicaid state agencies are not required to complete an EDI Enrollment Form as a condition for submission of 837 version 4010A1 subrogation claims directly to carriers or DMERCs. Although state agencies are issued a pseudo-provider number to permit their submission of these claims, since this version of the 837 did not permit 837 submission of a claim by other than a provider, they are not actually providers of care. Once a post-version 4010A1837 implementation guide is implemented, state agencies will be able to submit claims without use of a pseudo-provider number.

3. Due to the unique beneficiary zip code rule that applies to processing of supplier claims, a supplier is sometimes required to submit claims to DMERCs that do not have a copy of their EDI Enrollment Form. Suppliers are also more likely to become confused and submit a beneficiary claim to their local DMERC even though the claim falls under the jurisdiction of a different DMERC. Unlike carriers or FIs, DMERCs are not permitted to reject claims when received from out of area suppliers, but must transfer those misdirected claims to the proper DMERC.

Providers who have a signed EDI Enrollment Form on file with a particular carrier, DMERC or FI are not required to submit a new signed EDI Enrollment Form to the same carrier, DMERC, or FI each time they change their method of electronic billing or use of another type of EDI transaction, e.g. changing from direct submission to submission through a clearinghouse or changing from one billing agent to another. However, contractors must inform providers that providers are obligated to notify their contractor(s) by fax or hardcopy in advance of a change that involves a change in the billing agent(s) or clearinghouse(s) used by the provider, the effective date on which the provider will discontinue using a specific billing agent and/or clearinghouse, if the provider wants to begin to use additional types of EDI transactions, or of other changes that might impact their use of EDI. Providers are not required to notify their Medicare contractor if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance. When a contractor receives a signed request from a provider or supplier to accept EDI transactions from or send EDI transactions to a third

party, the contractor must verify that an EDI Enrollment Form is already on file for that provider or supplier, and that the third party has already been issued an EDI number and password to permit submission/receipt of EDI transactions. The request cannot be processed until both are submitted/issued.

The binding information in an EDI Enrollment Form does not expire if the person who signed that form for a provider is no longer employed by the provider, or that carrier, DMERC, or FI is no longer associated with the Medicare program. Medicare responsibility for EDI oversight and administration is simply transferred in that case to that entity that CMS chooses to replace that carrier, DMERC, or FI, and the provider as an entity retains responsibility for those requirements mentioned in the form regardless of any change in personnel on staff.

An organization comprised of multiple components that have been assigned more than one Medicare provider number, supplier number, or UPIN may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which such numbers have been assigned. The organization is responsible for the performance of its components.

The note at the end of the enrollment agreement language indicates that either party can terminate that agreement by providing 30 days advance notice. There is an exception to that requirement. In the event a Medicare carrier, DMERC, or FI detects abuse of use of an EDI system ID or password, or discovers potential fraud or abuse involving claims submitted electronically, electronic requests for beneficiary eligibility data, or other EDI transactions, that Medicare contractor is to immediately terminate system access for submission or receipt of EDI transactions by that individual or entity. A decision by a Medicare contractor to terminate or suspend EDI access in such a situation is not subject to appeal by the individual or entity that loses EDI access.

Electronic Data Interchange (EDI) Enrollment Information Required for Inclusion at a Minimum in Each Carrier, DMERC, and FI EDI Enrollment Form

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers, DMERCs, or FIs:

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contractor by itself, its employees, or its agents;

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its carriers, DMERCs, FIs, or another contractor if so designated by CMS without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law;

3. That it will submit claims only on behalf of those Medicare beneficiaries who have given their written authorization to do so, and to certify that required

beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file;

4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:

    - Beneficiary's name;
    - Beneficiary's health insurance claim number;
    - Date(s) of service;
    - Diagnosis/nature of illness; and
    - Procedure/service performed.

5. That the Secretary of Health and Human Services or his/her designee and/or the carrier, DMERC, FI, or other contractor if designated by CMS has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and CMS guidelines;

6. That it will ensure that all claims for Medicare primary payment have been developed for other insurance involvement and that Medicare is the primary payer;

7. That it will submit claims that are accurate, complete, and truthful;

8. That it will retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least six years, three months after the bill is paid;

9. That it will affix the CMS-assigned unique identifier number (submitter identifier) of the provider on each claim electronically transmitted to the carrier, DMERC, FI, or other contractor if designated by CMS;

10. That the CMS-assigned unique identifier number (submitter identifier) constitutes the provider's legal electronic signature and constitutes an assurance by the provider that services were performed as billed;

11. That it will use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access;

12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law;

13. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its carrier, DMERC, FI, or other contractor if designated by CMS shall not be used by agents, officers, or employees of the billing service except as provided by the carrier, DMERC, or FI (in accordance with §1106(a) of Social Security Act (the Act);

14. That it will research and correct claim discrepancies;

15. That it will notify the carrier, DMERC, FI, or other contractor if designated by CMS within two business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare & Medicaid Services (CMS) agrees to:

1. Transmit to the provider an acknowledgment of claim receipt;

2. Affix the FI/carrier/DMERC or other contractor if designated by CMS number, as its electronic signature, on each remittance advice sent to the provider;

3. Ensure that payments to providers are timely in accordance with CMS' policies;

4. Ensure that no carrier, DMERC, FI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, DMERC, or FI or from any subsidiary of the carrier, DMERC, FI, other contractor if designated by CMS, or from any company for which the carrier, DMERC, or FI has an interest. The carrier, DMERC, FI, or other contractor if designated by CMS will make alternative means available to any electronic biller to obtain such services;

5. Ensure that all Medicare electronic billers have equal access to any services that CMS requires Medicare carriers, DMERC, FIs, or other contractors if designated by CMS to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the carrier, DMERC, FI, or other contractor if designated by CMS sells directly, or indirectly, or by arrangement;

6. Notify the provider within two business days if any transmitted data are received in an unintelligible or garbled form.

NOTE: Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to the carrier, DMERC, FI, or other contractor if designated by CMS. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. Signature

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Provider's Name

Title

Address

City/State/Zip

By _____ _____

(signature) (printed name)

Title

Date

20.2 - Submitter Number

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, FIs, or other contractors if designated by CMS will assign an EDI submitter/receiver number and a periodically renewable password to each entity (provider, clearinghouse, billing agent) submitting or receiving electronic transactions. Provision must be made to return claim remittance files either to the provider or to a designated receiver (which may be the submitter or another entity). If electronic remittance advice transactions will be issued, the profile must indicate where the carrier, DMERC, FI, or other contractor if designated by CMS is to send the remittance advice transactions.

20.3 - Release of Medicare Eligibility Data

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

The CMS is required by law to protect all Medicare beneficiary-specific information from unauthorized use or disclosure. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and HIPAA. CMS instructions allow release of eligibility data to providers or their authorized billing agents for the purpose of preparing an accurate claim. Such information may not be disclosed to anyone other than the provider, supplier, or beneficiary for whom the claim was filed.

Clearinghouses or other third parties that obtain beneficiary eligibility data on behalf of providers that serve those beneficiaries are sometimes referred to as Network Service Vendors (NSVs). See section 80.3 for further information regarding NSVs. carriers, DMERCs, FIs, or other contractors if designated by CMS must give access to any network service vendor that requests access to eligibility data on behalf of providers as long as they adhere to the following rules:

- Each network service vendor/clearinghouse must sign a Network Service Vendor (NSV) Agreement (below);

- Each provider that contracts with an NSV must sign a valid EDI Enrollment Form before eligibility data can be sent to the third party;

- The provider must explain the type of EDI services to be furnished by its clearinghouse/network service vendor in a signed statement authorizing the vendor's access to eligibility data;

- The clearinghouse/NSV must be able to associate each inquiry with the provider making the inquiry. That is, for each inquiry made by a provider through a clearinghouse/NSV, that vendor must be able to identify the correct provider making the request for each beneficiary's information and be able to assure that eligibility responses are routed only to the provider that originated each request; and

- There is no record of prior violation of a clearinghouse/NSV agreement by this clearinghouse/NSV with the Medicare contractor to whom a request for access to the eligibility data is submitted that would indicate that beneficiary data could be at risk of improper disclosure if access was approved for this clearinghouse/NSV.

A. All providers and clearinghouses/NSVs that wish to obtain Medicare beneficiary eligibility data must apply to a FI/carrier/DMERC, or other contractor if designated by CMS for access to the eligibility records.

B. Providers and clearinghouses must submit each eligibility query to the carrier, DMERC or FI to which each provider is required to submit its claims for that beneficiary. They are not currently permitted to access Medicare beneficiary eligibility information for the entire U.S. via a single carrier, DMERC, FI, the Combined Working File (CWF),

or another Medicare contractor or system pending availability of the X12N 270/271 version 4010A1. (See Chapter 31.)

C. When an inquiry enters into the carrier, DMERC, FI, or other contractor if designated by CMS system, the FI, carrier, DMERC, or other contractor if designated by CMS must be able to ensure that:

- An EDI agreement has been signed by the provider;
- A clearinghouse/NSV agreement has been signed by the vendor; and
- Each inquiry identifies the provider that initiated the query and to which the response will be routed.

D. Pending completion of Medicare implementation of the X12N 270/271 version 4010A1 implementation Guide (IG), FIs must include the CMS-specified eligibility institutional data set in a proprietary format to electronically issue eligibility data. Carriers must issue eligibility data in the X12N 270/271 Health Care Eligibility/Benefit Inquiry and Response version 3051 IG Format. DMERCs must continue to use a proprietary format to respond to electronic eligibility data queries.

E. Providers must be notified that: they may obtain eligibility data only for the approved use of preparing accurate Medicare claims; Access to eligibility data is limited to individuals within a provider's organization who are involved in claim preparation and submission; and that providers and their authorized third party agents must agree not to request eligibility data for a beneficiary unless the provider has been contacted by the beneficiary, a personal representative of a beneficiary such as a relative or friend, or a health care provider currently treating the beneficiary concerning provision of health care services or supplies to the beneficiary.

Carriers, DMERCs, FIs, or other contractors if designated by CMS must notify all providers that request electronic receipt of eligibility data of these requirements. Carriers, DMERCs, FIs, or other contractors if designated by CMS must remind providers that they must let them know when they change from one clearinghouse/NSV to another, cease arrangements with a clearinghouse/NSV, or leave the Medicare program. Carriers, DMERCs, FIs, or other contractors if designated by CMS must delete each provider from their EDI eligibility security file if the carrier, DMERC, FI, or other contractor will no longer be responsible for processing of the provider's claims or if the provider or the carrier/DMERC/FI/other contractor is no longer serving the Medicare program. Carriers, DMERCs, FIs, and other contractors if designated by CMS must remind providers, clearinghouses/NSVs and other third parties that they can lose access rights to beneficiary eligibility data if they fail to adhere to the requirements for access.

20.4 - Network Service Vendor (NSV) Agreement

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Third party agents that represent providers, including NSVs, certain value-added networks, clearinghouses, and billing agents that will obtain Medicare beneficiary eligibility data, must sign an agreement that includes the following wording:

The third party provider agent agrees that:

1. All beneficiary-specific information is confidential and subject to the provisions of the Privacy Act of 1974, which requires Federal information systems to establish appropriate safeguards to ensure the security and confidentiality of individually identifiable records. This includes eligibility information, claims, remittance advice, online claims correction, and any other transaction where any individually identifiable information applicable to a Medicare beneficiary is processed or submitted electronically;

2. It is has no ownership rights and is not a user of the data, but merely a means of transmitting data between users that have a need for the data and are already identified as legitimate users under a "routine use" of the system; that is, disclosure for purposes that are compatible with the purpose for which Medicare collects the information;

3. The beneficiary eligibility data submitted to them by the carrier, DMERC, FI, or other contractor if designated by CMS are owned by Medicare;

4. It will not disclose any information concerning a Medicare beneficiary to any person or organization other than (a) an authorized Medicare provider making an inquiry concerning a Medicare beneficiary who is the provider's patient, (b) CMS, or (c) CMS' carriers, DMERCs, FIs, or other contractors as designated by CMS;

5. It will promptly notify the carrier, DMERC, FI, or other contractor if designated by CMS of any unauthorized disclosure of information about a Medicare beneficiary and will cooperate to prevent further unauthorized disclosure;

6. The data will not be stored for any duration longer than that required to assure that they have reached their destination, and no more than 30 days for any purpose;

7. It has identified to the carrier, DMERC, FI, or other contractor if designated by CMS in writing of any instances where it would need to view Medicare data in order to perform its intended tasks under the agreement. It will not view the data unless it is absolutely necessary to perform its intended tasks;

8. It will not prepare any reports, summary or otherwise, based on any individual aspect of the data content. Reports may be written, however, on data externals or summaries such as the number of records transmitted to a given receiver on a given date;

9. It will guarantee that an authorized user may be deleted within 24 hours in the event that person leaves their employment, no longer has a need to access this information, or there is a possible security breach. It will specify in writing other

standards of performance, including, but not limited to, how quickly a user may be added to the network;

10. No incoming or outgoing electronic data interchange (EDI) will be conducted unless authorization for access is in writing, signed by the provider, submitted to the provider's carrier, DMERC, intermediary, or other contractor if designated by CMS, and each provider has a valid EDI enrollment form on file with that CMS contractor;

11. It has safeguards in place to assure each eligibility response is sent only to the provider that initiated the inquiry;

12. It will furnish, upon request, documentation that assures the above privacy and security concerns are being met;

13. It will adhere to the regulations on security and privacy standards for health information under the Health Insurance Portability and Accountability Act of 1996;

14. It will require its subcontractors, agents, and business associates to comply with all applicable current requirements of this agreement as well as any future requirements or changes to this agreement; and

15. It will comply with CMS Internet policy. (CMS does permit the transmission of protected health data between providers and other parties who are not Medicare contractors over the Internet if it is authenticated and encrypted. The CMS policy requires written notification of intent from organizations anticipating use of the Internet. The CMS reserves the right to require the submission of documentation to demonstrate compliance with requirements, or to conduct on-site audits to ascertain compliance.)

NOTE: Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document. This document shall become effective when signed by the third party agent. The responsibilities and obligations contained in this document will remain in effect as long as electronic data interchange is being conducted with a carrier, DMERC, FI, or other contractor if designated by CMS. Either party may terminate this arrangement by giving the other party thirty (30) days notice of its intent to terminate.

SIGNATURE: I am authorized to sign this document on behalf of the indicated party, and I have read and agree to the forgoing provisions and acknowledge same by signing below.

Sole Proprietor or Company Name:

Address:

City/State/ZIP code:

Signed By: _____ _____

(signature) (printed name)

Title:

Date:

Carrier, DMERC, FI/other contractor if designated by CMS to whom this is being submitted:

20.5 - EDI User Guidelines

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

FIs, carriers, and DMERCs must make EDI information available to new users that describe the various steps in the testing process (see §30 and §60) and discloses:

- The names and telephone numbers of appropriate staff to contact when:
  - Getting started with EDI;
  - Needing on-going support for electronic transactions; and
  - Needing support for general billing issues;
- Testing requirements and the submitter's and carrier, DMERC, or FI's level of responsibility throughout each step of the testing phase;
- The availability of the appropriate specifications for this provider:
  - American National Standards Institute's (ANSI) Accredited Standards Committee (ASC) X12N transactions adopted under HIPAA; and
  - National Council for Prescription Drug Programs Format (NCPDP) adopted under HIPAA.
- The availability of free Medicare electronic claim submission software upon request;
- *Instructions for accessing and downloading CMS EDI instructions via the CMS Internet EDI Home Page*
  http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp
- Login requirements;
- Telecommunications options and requirements; and
- Frequently asked questions and answers about EDI.

20.6 - Directory of Billing Software Vendors and Clearinghouses

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs must maintain a directory of electronic billing software vendors and clearinghouses that have successfully completed software and/or submission testing for the X12 837 version 4010A1 and NCPDP (applies to DMERCs only) Telecommunication standard 5.1 and Batch standard 1.1 claim transactions adopted as national claim standards for HIPAA. Carriers, DMERCs, and FIs must make this directory available to their providers via a Web page or electronic bulletin board. Carriers, DMERCs, and FIs must update the directory whenever software from additional software vendors and additional clearinghouses is moved into production. At a minimum, the directory must include the vendor/clearinghouse name, phone number, address, software product name, and production version. Carriers, DMERCs, and FIs should also note any additional transactions for which the tested software can be used for submission or receipt of HIPAA transactions other than the claim.

30 - Technical Requirements - Data, Media, and Telecommunications

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs may not differentiate between a subsidiary of a parent organization and direct EDI transaction submitters when providing EDI support, but must provide the same level of support and quality of service to both.

30.1 - System Availability

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Access to lookup files (e.g., HCPCS codes, fee schedules) may be dependent upon hours the core processing system is available. Where EDI functions are dependent upon the operation of the host processing system, the host system's hours of operation determine system availability. Carriers, DMERCs, and FIs shall inform users of system availability schedules including any planned downtime for system maintenance.

30.2 - Media

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

An EDI transaction is defined by its initial manner of receipt. Depending upon the capability of a carrier, DMERC, or FI and the details as negotiated between carrier/DMERC/FI and electronic claim submitters, an electronic claim could be submitted via central processing unit (CPU) to CPU transmission, dial up frame relay, direct wire (T-1 line or similar), or personal computer modem upload or download (also see §30.3).

When counting electronic claims for workload reporting, the contractor includes data on all bills received for initial processing from providers (including all RHCs) directly or

indirectly through another FI, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. See § 90 of this chapter for information about application of the claims payment floor when a claim is submitted electronically in a non-HIPAA compliant format.

Carriers, DMERCs, and FIs are not permitted to classify the following as electronic claims for CROWD reporting, for payment floor or Administrative Simplification Compliance Act (ASCA, see section 90) mandatory electronic claim submission purposes:

- Bills received from providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for these bills;
- Adjustment bills (FIs only);
- Misdirected bills transferred to another carrier, DMERC, or FI;
- HHA bills where no utilization is chargeable and no payment has been made, but which have been requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.);
- Bills paid by an HMO and processed by the contractor; and
- Transactions submitted on diskettes, CDs, DVDs or similar storage media that should only be accepted as part of a disaster recovery process.

Carriers, DMERCs, and FIs are permitted to accept claims via fax-imaging, tape/diskette/similar storage media if they can demonstrate to CMS that it is cost effective, but carriers, DMERCs, and FIs are to assist billers using such media to transition to more efficient electronic media, such as the free Medicare claim submission or commercially available software that are considered to be more cost effective.

30.3 - Telecommunications and Transmission Protocols

(Rev. 615, Issued: 07-22-05, Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs must support transfers for Medicare using 56.6 KB or faster connections on the majority of their asynchronous communications lines. For asynchronous communications, carriers, DMERCs, and FIs must support provider access through Transmission Control Protocol/Internet Protocol (TCP/IP), compliant with Internet Request for Comment (RFC) number 1122 and 1123, using Serial Line Internet Protocol (SLIP) or Point-to-Point Protocol (PPP). For any EDI transfers over TCP/IP connections, carriers, DMERCs, and FIs must support a File Transfer Protocol (FTP) compliant with RFC 959. FTP servers provide for user authentication through user ID/password mechanisms. The carrier, DMERC, or FI must submit any other security mechanism in addition to this to CMS for approval prior to implementation. Any user

should be able to use TCP/IP for asynchronous communication at any Medicare site. The Internet may not be used for beneficiary sensitive data at this time, except as expressly approved by CMS as a part of a demonstration project.

Carriers, DMERCs, and FIs must provide asynchronous telecommunications to any requesting EDI user. Carriers, DMERCs, and FIs must offer data compression, either through the use of the v.34 56.6 KB modem or through PKZIP version 2.04g, whichever an EDI transaction sender/receiver requests. While PKZIP is the standard, carriers, DMERCs, or FIs may, but are not required to, accommodate other compression software which an EDI submitter may request. Carriers, DMERCs, and FIs must enable hardware compression support in their v.34 modems (the actual use is negotiated between the carrier, DMERCs, or FI modem and the provider modem at startup). In addition, when hardware compression is used, it is possible for the effective data rate to the host system to be as much as four times the line rate (e.g., 4 times 56.6). Therefore, carriers, DMERCs, and FIs should have adequate processing capacity to handle this amount of data for each connection.

NOTE: Contractors need not support file compression for X12N transactions. Compression is permitted between the contractor and its data center, if applicable. However, the Medicare flat files must not be compressed when presented to the shared system.

For asynchronous traffic, carriers, DMERCs, and FIs may not limit the number of 837 transactions or the number of providers with transactions included in a single transmission, but they may limit a single transmission to 5,000 claims if that is necessary for efficient operations. Server capacity must be adequate to support simultaneous sustained file transfers from all configured communications lines.

For asynchronous communications, carriers, DMERCs, and FIs must accept and send all X12 transactions as a continuous byte stream or as a variable length record. Carriers, DMERCs, and FIs are not permitted to require that provider EDI transaction data be broken down into 80 byte segments and may not require any other deviation from the variable length format or the continuous byte stream format. For example, submitters may not be forced to create each segment as its own record by inserting carriage returns or line feeds. Only standard X12 envelopes may be used with X12 transactions.

Prior to expiration of the HIPAA contingency period, for asynchronous communications, carriers and DMERCs must accept and send the NSF (claim and remittance respectively) in 320 byte records, and FIs must accept the UB-92 in 192 byte records. Neither carriers, DMERCs, nor FIs may require that the data be broken down into 80 byte segments nor may any other deviation from the 192 or 320 byte formats be required. For asynchronous communications, Medicare flat files are self-enveloped, and the envelope provided shall be the only one used.

The X12 transactions are variable-length records designed for wire transmission. Medicare contractors must be able to accept them over a wire connection. Each sender and receiver must agree on the blocking factor and/or other pertinent telecommunication protocols.

Unless approved for participation in a limited demonstration program, carriers, DMERCs, and FIs are not permitted to accept EDI transactions via the Internet at this time.

30.4 - Toll-Free Service

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Toll free lines are not available for submission or receipt of EDI transactions. Providers and their agents are responsible for costs they incur, including telephone line costs for delivery of EDI transactions to carriers, DMERCs, and FIs or to pick up outgoing Medicare EDI transactions that have been deposited to an electronic mailbox for downloading.

30.5 - Initial Editing

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs are required to edit submitted transactions at the front end to determine whether they are sufficiently complete to enable processing. Transactions that are not legible, or do not include adequate data to be considered an acceptable EDI transaction, must be rejected or returned as unprocessable. "Rejected" or "returned" transactions are not classified as "received" by Medicare. Carrier, DMERCs, and FIs are not required to assign a control number or a receipt date to those transactions. Nor are they required to retain any record of those transactions pending correction and resubmission by the original sender. See § 50 and § 70 of this chapter for further editing and testing requirements.

30.6 - Translators

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

The FIs, carriers, and DMERCs must accept HIPAA compliant transactions into their front-end system and translate that data into the appropriate flat file format for the transaction type to enable processing by their shared system. HIPAA compliant transactions may include Medicare data (data sent to the core shared system) and non-Medicare data (data not sent to the core shared system). Translators are required to validate the syntax compliance of each inbound transaction against the ANSI accredited organization standards upon which the implementation guides adopted by HIPAA are based. Syntax edits must be limited to those syntax requirements specified in those ANSI accredited standard implementation guides (IGs).

The FIs, carriers, and DMERCs must use the X12 997 Functional Acknowledgment to report X12 transaction standard level errors detected by translators and to acknowledge receipt of claims that did not contain syntax errors, unless the submitter has indicated a preference not to receive acknowledgements for claims without errors. FIs, carriers, and DMERCs may purge X12 997 transactions from submitter mailboxes after five (5) business days in the event not downloaded by the submitting entity, but are encouraged to

retain these as long as 30 days if system capacity permits. Once purged, a contractor is not required to be able to recreate that 997. A provider or clearinghouse that failed to download the 997 timely may submit a claim status query to obtain comparable information for accepted claims. If that response indicates no record of the claim(s), suggesting front end rejection due to a syntax error, the provider/clearinghouse can resubmit the claim and have a new 997 issued. Requirements for the X12 997 are located in Appendix B at the rear of each X12 IG adopted under HIPAA. Carriers, DMERCs, and FIs are required to meet those Appendix B requirements when issuing 997s.

When receiving claims in the HIPAA adopted NCPDP formats, DMERCs must produce a response file in the NCPDP format containing one Transaction Header and one Transaction Trailer with the appropriate syntax error noted in the message field.

The FIs, carriers, and DMERCs must accept the basic character set on an inbound X12N transaction adopted under HIPAA, plus lower case and the "@" sign which are part of the extended character set. Refer to Appendix A, page A2, of each IG for a description of the basic character set. All other character sets may be rejected at the translation level. If FIs and/or carriers/DMERCs cannot accept more than 9,999 loops or segments per loop in an X12 transaction due to the limitations of their translator, they may reject the transaction at the translator level and use the X12 997 AK3 segment with a value of "4" in data element "04." Translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) that surround individual transactions so the translation process can immediately reject an interchange, functional group, or transaction set not having met the requirements contained in the specific structure, which could cause software failure when mapping to the flat file. FIs, carriers, and DMERCs are not required to accept multiple functional groups (GS/GE) within one transmission for X12 transactions.

Translators must also:

- Convert lower case to upper case;
- Pass all spaces to the flat file for fields that are not present in an inbound transaction but which are included in the flat file;
- Map "Not Used" data elements for carriers/DMERCs based upon that segment's definition only, i.e., if a data element is never used, do not map it. However, if a data element is "required" or "situational" in some segments but not used in others, then it must be mapped; "Not Used" data elements are not to be mapped to the FI flat file;
- Remove the hyphen from all range of dates with a qualifier of "RD8" when mapping to the flat file;
- Accept multiple interchange envelopes within a single transmission; and
- Translate data for outgoing transactions supplied by the shared system in the flat file format into the appropriate, compliant IG standard as adopted under HIPAA. Translation of outgoing transactions is to follow the same character set and case

requirements noted for incoming translation. FIs and carriers are not required to accept or process X12 997 transactions from trading partners for any outgoing X12 transactions.

- See§ 70 for additional FI, carrier, and DMERC translator edit requirements that may be specific to individual standards.

30.7 – Claim Key Shop and Optical Character Recognition (OCR)/Image Character Recognition (ICR) Mapping to X12N Based Flat File

(Rev. 162, 4-30-04)

CMS will cease support of the NSF once the Health Insurance Portability and Accountability Act (HIPAA) contingency plan ends. Therefore, migration to the either the X12N-based flat file or the HIPAA 837 as the output format for key shop and OCR/ICR claims will need to occur.

Carrier and DMERC key shop operations, that do not use either the HIPAA 837 or X12N-based flat file as output, must create the output from paper claims in the X12N-based flat file format or the HIPAA 837. When the X12N-based flat file is the output the REF01 segment/element (found prior to the ST segment) shall contain a value of "+PR" and REF02 shall contain a value of "K" (key shop) or "O" (OCR/ICR).

Carriers and DMERCs who support telephone claim submission shall convert the output to the X12N-based flat file. The value in REF02 shall contain a "T" (teleclaim).

The carrier/DMERC shared system shall apply implementation guide edits only to those requirements that are applicable to both the HIPAA and the corresponding fields on the paper claim. Implementation guide edits that are inappropriate for paper claims shall be by-passed.

40 - Required Electronic Data Exchange Formats

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

40.1 - General HIPAA EDI Requirements

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

The following HIPAA transaction standards must be supported by the Medicare FIs, carriers, and DMERCs for the electronic exchange of data with Medicare providers/submitters/COB trading partners. Electronic transactions that do not fully comply with the implementation guide requirements for these formats will be rejected:

- *X12N 837 implementation guide (IG) version 4010A1 for Institutional(I) and Professional (P) claims can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp and*

coordination of benefits (COB) with other payers can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/12_COB.asp ;

- *NCPDP Telecommunication Standard Specifications and IG version 5.1 and Batch Standard 1.1 for retail prescription drug claims (billed to DMERCs only) and COB (see § 40.1 of this chapter for additional information) can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp;*

- *X12 835 IG version 4010A1 for Remittance Advice (see Chapter 22 for additional information) and can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp; and*

- *X12 276/277 IG version 4010A1 for Claim Status Inquiry & Response (see Chapter 31 for additional information) can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp*

Medicare FIs, carriers, and DMERCs will not be involved in Medicare acceptance and processing of the X12 270/271 IG version 4010A1 transactions for Beneficiary Eligibility Inquiry & Response but information on that transaction is available at www.cms.hhs.gov/ElectronicBillingEDITrans/09_Eligibility.asp. The 270 transaction will be accepted and processed, and a 271 returned by CMS directly. See Chapter 31 for further information.

Although not mandated by HIPAA, as noted in § 30.6, CMS also requires that carriers, DMERCs, and FIs issue an X12 997 transaction to electronic claim submitters to acknowledge receipt of claims (except where waived by a submitter) and to report syntax errors related to any X12N transactions submitted to Medicare.

The initial HIPAA transactions regulation required that covered entities eliminate use of electronic formats and versions not adopted as national standards under HIPAA by October 16, 2002 (applies only to the transaction types addressed by HIPAA). Subsequent legislation in the Administrative Simplification Compliance Act (ASCA) permitted covered entities to apply for a 1-year extension to October 16, 2003, to enable them to complete implementation of the standards mandated by HIPAA. Most covered entities, including Medicare, did request that extension. As a significant portion of the covered entities had still not completed implementation by October 16, 2003, to avoid disruption in health care payments and services, the Secretary of Health and Human Services (HHS) allowed payers to implement contingency plans effective October 16, 2003 to temporarily continue to support pre-HIPAA transaction standards. The contingency plans were permitted to allow additional implementation time for those providers and clearinghouses making a good faith effort to become compliant with the HIPAA transaction requirements to complete work in progress.

CMS announced on August 4, 2005 that the Medicare HIPAA inbound claims contingency plan will end on October 1, 2005. That means that all electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the NCPDP requirements will be rejected. The Medicare contingency plan for the

X12 835, 276/277 (version 4010 support will need to be terminated), 837 claims that Medicare sends to another payer as provided for in a trading partner agreement, and the 270/271 version 4010A1 transactions remain in effect pending further notice. CMS will issue advance notice to the health care industry when a decision is reached to terminate the remaining Medicare contingency plans.

See Pub.100-09, the Medicare Contractor Beneficiary and Provider Communications Manual, regarding contractor requirements for furnishing information to providers via the Internet and alternate methods to be used to furnish information to those providers that lack Internet access. Contractors are permitted to charge providers up to $25 to recoup their costs for manual distribution of free billing or PC-Print software via diskette, CD, or other hard media which providers are normally expected to download via the Internet. Contractors are to notify new users of EDI that they should make arrangements to enable them to download later format, and most related coding updates, via the Internet.

An overview of any changes to existing specifications, including effective dates will be issued to providers via carrier, DMERC, or FI bulletins, on their Web page, and will also be available via the Internet as Manual transmittals which can be viewed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp. to the page for each type of transaction. These overviews will identify the Web site address and record title where the specifications for the changes will be recorded.

40.1.1 - Submitting Change Requests for the UB-92

(Rev. 1, 10-01-03)

A3-3602.6

Change requests must be submitted on the electronic UB-92 Change Request Form. The form must be completed properly and any necessary documentation attached. FIs may also submit change requests for non-Medicare commercial operations. Complete the form as follows:

Line 1 - Enter the Region Number (e.g., Regions I-X) and the date of the request.

Line 2 - Enter the name/organization.

Line 3 - Enter the name of a contact person in the organization that can answer questions concerning the request.

Line 4 - Enter the contact person’s telephone number.

Line 5 - Enter the record type (record identifier) and field that is requested to be revised, deleted, or added. Check the appropriate box to indicate whether this is a request to add a new field, delete a field, or revise an existing field.

Line 6 - Check the box to indicate at which level the field is/should be located.

Use the remainder of the form to describe the change request and the reason(s) for the change. Also, include a discussion of the impact of the change, and attach any supporting documentation.

Indicate whether this change is the result of a CMS mandate.

ELECTRONIC UB-92 CHANGE REQUEST FORM

1. Region: _____ Date:_____

2. Name/Organization: _____

3. Contact Person: _____

4. Phone #: _____

5. Record Type & Field:
_____ [___] New [___] Delete [___] Revised

6. Level: [___] File [___] Batch [___] Claim [___] Line Item

Description of Change Being Requested:

_____

Reason for Change:

_____

Impact Statement: (Volume, lines of business involved, field attributes/values, definition, validation, etc.)

_____

ATTACH ANY DOCUMENTATION WHICH CLARIFIES THIS REQUEST

Is change request a result of a CMS Mandate? [___] No [___] Yes

DO NOT COMPLETE THE FOLLOWING SECTION

Control Number: _____

Final Disposition: [___] Approved for Electronic UB-92 Release Date:

_____

[___] Denied

Remarks:

_____

_____

_____

_____

_____

_____

NOTE: Send this form to the RO EDI Coordinator.

40.1.2 - Submitting Change Requests for the NSF

(Rev. 1, 10-01-03)

B3-3025

Central office (CO) maintains the National Standard Format (NSF) for electronic media claims (EMC) and for electronic remittance advice (ERA) transactions.

Change requests must be submitted to the RO EDI Coordinator on the NSF Change Request Form. The form must be completed properly and any necessary documentation attached. Carriers may also use this form to submit change requests for non-Medicare commercial carriers.

The form is completed as follows:

Line 1 - Enter the region number (e.g., Regions I-X) and the date of the request;

Line 2 - Enter the name/organization;

Line 3 - Enter the name of a contact person in the organization that can answer questions concerning the request;

Line 4 - Enter the contact person’s telephone number;

Line 5 - Enter the record type (record identifier) and field that is requested to be revised, deleted, or added. Check the appropriate box to indicate whether this is a request to add a new field, delete a field, or revise an existing field;

Line 6 - Check the box to indicate at which level the field is/should be located.

Use the remainder of the form to describe the change request and the reason(s) for the change. Also, include a discussion of the impact of the change, and attach any supporting documentation. Indicate whether this change is the result of a CMS mandate.

NATIONAL STANDARD FORMAT CHANGE REQUEST FORM

1. Region: _____

   Date: _____

2. Name/Organization: _____

3. Contact Person: _____

4. Phone #: _____

5. Record Type & Field:

_____ [___] New [___] Delete [___] Revised

6. Level: [___] File [___] Batch [___] Claim [___] Line Item

Description of Change Being Requested:
_____

Reason for Change:
_____

Impact Statement: (Volume, lines of business involved, field attributes/values,

definition, validation, etc.)

_____

_____

_____

ATTACH ANY DOCUMENTATION WHICH CLARIFIES THIS REQUEST

Is change request a result of a **CMS** Mandate? [___] No [___] Yes

DO NOT COMPLETE THE FOLLOWING SECTION

Control Number: _____

Final Disposition: [___] Approved for NSF Release

Date: _____

[___] Denied

Remarks:

_____

_____

_____

_____

NOTE: Send this form to the RO EMC Coordinator. Non-Medicare commercial carriers may send this form to a Medicare carrier or CMS CO.

40.1.3 - FI HIPAA Claim Level Edits

(Rev. 49, 12-19-03)

The FIs must reject 837 claims with implementation guide (IG) errors at the claim level. FIs must install the APASS IG edit module in order to reject claims that have implementation guide (IG) errors at the claim level (see example below). If a batch of claims passes the basic syntax edits, the APASS IG edit module will be invoked and only claims that fail the IG edits will be rejected and appropriate reports generated.

ISA (example 1)

GS (example 2)

ST (example 3)

PROV A

SUBSCRIBER A (example 5)

CLAIM A1 (example 6)

CLAIM A2

CLAIM A3

SUBSCRIBER AA

CLAIM AA1

CLAIM AA2

PROV B (example 4)

SUBSCRIBER B

CLAIM B1

CLAIM B2 (example 6)

CLAIM B3

SE

ST

PROV C

SUBSCRIBER C

CLAIM C1

CLAIM C2

CLAIM C3 (example 6)

PROV D

SUBSCRIBER D

CLAIM D1

CLAIM D2

CLAIM D3

SE

GE

IEA

Example 1 (ISA-IEA level IG edit): Any errors found at this level (envelope) will result in all claims within the ISA-IEA being rejected.

Example 2 (GS-GE level IG edit): Any errors found at this level will result in all claims within the GS-GE being rejected. In this example all claims would be rejected. If a second GS-GE loop followed the first and passed all edits, then any claims within the second GS-GE would be entered into the system providing they passed the IG edits.

Example 3 (ST-SE level IG edit): Any errors found at this level will result in all claims within the ST-SE being rejected. In this example assume only the first ST had errors. In this case claims A1, A2, A3, B1, B2, B3 would be rejected. Claims C1, C2, C3, D1, D2, D3 would be entered into the system providing they passed IG edits.

Example 4 (Provider level IG edit): Any errors found at this level will result in all claims for this provider being rejected. In this example assume only the Provider B had errors (such as an invalid provider number). In this case, claims A1, A2, A3, C1, C2, C3, D1, D2, D3 would be entered into the system providing they passed IG edits and claims B1, B2, B3 would be rejected.

Example 5 (Subscriber level IG edit): Any errors found at this level will result in all claims for this subscriber being rejected. In this example, claims for Subscriber A (A1, A2, and A3) would be rejected. Claims for Subscriber AA (AA1 and AA2) would be entered into the system providing they passed IG edits.

Example 6 (Claim level IG edit): Any errors found at this level will result in only that claim(s) being rejected. In this example assume only claims A1, B2 and C3 had errors. All of the other claims would be entered into the system providing they passed IG edits.

40.2 - Continued Support of Pre-HIPAA EDI Formats

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Pending termination of the Medicare contingency plan for the HIPAA mandated transactions types other than claims sent to Medicare, carriers, DMERCs, and FIs are required to temporarily continue to support use of the following pre-HIPAA electronic transaction formats until the earlier of the effective date for CMS elimination of the HIPAA contingency plan that applies to each noted format, or the date when no further providers, billing agents, or clearinghouses are using those formats:

- X12 837 institutional (FIs only) and professional (carriers and DMERCs only) version 4010 and 3051, National Standard Format (NSF) version 3.01 (carriers and DMERCs only) and the UB-92 version 6.0 flat file claims for coordination of benefits sent to other payers under trading partner agreements;

- X12 835 versions 3030Ma, 3051.3A, and 3051.4A for remittance advice (FIs only);

- X12 835 IG versions 3030Mb, 3051.3B, and 3051.4B for remittance advice (carriers and DMERCs) and NSF versions 1.04, 2.01 and 3.01 (carriers and DMERCs);

- X12 270/271 IG version 3051 for eligibility query and response (carriers only);

- Proprietary format for eligibility data responses using the CMS standard eligibility data set; and

- X12 276/277 version 4010.

Carriers, DMERCs, and FIs must accept and provide these formats, where applicable for the noted transactions. See Chapters 22 (remittance advice), 25 (UB-92), 26 (CMS-1500), and 31(claim status and eligibility data) for additional information. *Specifications for each of these transactions can be found on the Washington Publishing Company Web site at http://www.wpc-edi.com/HIPAA for those X12 IGs (other than the NCPDP) adopted as national standards under HIPAA. CMS also publishes all HIPAA IG "companion documents". To access a companion document for a specific transaction, go to www.cms.hhs.gov/ElectronicBillingEDITrans and select the specific transaction on the left side of that screen. There will be a link to the companion document at the bottom of the page for that transaction.* "Companion documents" contain supplemental Medicare requirements and information for providers, vendors, clearinghouses, COB trading partners and/or Medicare carriers, DMERCs, and FIs on application of certain situational requirements, code usage, and Medicare interpretations of certain information in the IGs. Companion documents supplement but may not contradict the IGs. Companion documents are designed to clarify Medicare's expectations about use of situational loops, segments and data elements, and other Medicare-specific information that may impact reporting of data in the HIPAA transactions. Carriers, DMERCs, and

FIs are required to adhere to the requirements of the Medicare companion documents as well as the HIPAA standard transaction IGs.

X12 version 4010 IGs were initially adopted as first set of X12 national transaction standards under HIPAA, but were subsequently supplanted by an amended version, 4010A1. Medicare shared system maintainers were required to complete programming changes for implementation of the X12 version 4010A1 IGs that apply to Medicare (837 claim/COB, 835, 276/277) by April 1, 2003. In some cases, individual extensions were approved as result of contractor transitions between shared systems, or due to local issues.

40.3 - National Council for Prescription Drug Program (NCPDP) Claim Requirements

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

A. NCPDP Batch Transaction

The NCPDP batch transaction format is intended to provide a file transmission standard for submission in a non-real-time mode of the telecommunications standard transaction for drug claims from retail pharmacies. DMERCs will not accept retail pharmacy drug claims that are not submitted as batch transactions.

NCPDP users are required to transmit National Drug Codes (NDCs) in the NCPDP standard for identification of prescription drugs dispensed through a retail pharmacy. NDCs replace the drug HCPCS codes for retail pharmacy drug transactions billed to DMERCs via the NCPDP standard. The DMERC shared system (VMS) will convert NDCs to HCPCS codes for internal claim processing. The CMS will provide the HCPCS codes for these drugs, and an NDC to HCPCS crosswalk for use by VMS and the DMERCs.

B. Generating a Batch NCPDP Response

DMERCs will return the NCPDP batch response for all NCPDP transmissions received. The NCPDP term “transaction” is equivalent to a Medicare service or line item and the NCPDP term “transmission” is equivalent to a Medicare claim. The NCPDP implementation guide allows for up to 4 transactions (line items) per transmission (claim). This means that each claim can have up to 4 line items. Therefore, if one transaction (line item) rejects, the entire transmission (claim) will be returned. Each NCPDP batch can have up to 9,999,999,997 transmissions (claims). All transactions (up to 4) in the transmission will be treated as one claim, and each transmission in a batch will be treated as a separate claim. For a transmission (claim) where one or more claim transactions (lines) have errors, the following will occur:

1. DMERCs will reject all claim transactions (line items) in the transmission (claim) if any one claim (transmission) has detail errors.

2. The response status for all transactions will equal R (rejected).

3. The DMERCs will send up to 5 reject codes for claim transactions (line items) that have detail errors.

4. For the claim transactions (line items) that have no errors but are not being processed because of errors in other claim transactions (line items), the response status will equal R and the reject code will equal 84 (claim has not been paid/captured.)

5. Only the claim that rejected will have the reject codes other than 84. The other claims will have an 84 reject code indicating the claims were not paid/captured.

C. NCPDP Implementation Guide (IG) Edits

DMERCs must allow segments to be submitted in any order including AM07, AM03 and AM11 as permitted by the NCPDP standard.

D. NCPDP Narrative Portion of Prior Authorization Segment

Certain informational modifiers are required to identify compound ingredients in locally prepared medication. The NCPDP format does not currently support reporting modifiers in the compound segment. Therefore, the narrative portion in the prior authorization segment is being used to report these modifiers. The following must be entered in positions 001-003 of the narrative (Example, MMN or MNF). Starting at position 355, indicate the two-byte ingredient number followed by the two-position modifier:

CMN - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information

CNA - Indicates that the supporting documentation that follows is Medicare required CMN or DIF and narrative information

CFA - Indicates that the supporting documentation that follows is Medicare required

CMN or DIF information and Facility Name and Address

CNF - Indicates that the supporting documentation that follows is Medicare required

CMN or DIF information, narrative information, and Facility Name and Address

FAC - Indicates that the supporting documentation that follows is Medicare required Facility Name and address

FAN - Indicates that the supporting documentation that follows is Medicare required Facility Name and Address and narrative information

NAR - Indicates that the supporting documentation that follows is Medicare required Narrative Information

MMN - Indicates that the supporting documentation that follows is Medicare modifier information and CMN or DIF information

MNA - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and narrative information

MFA - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and Facility Name and Address

MNF - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and Facility Name and Address

MAC - Indicates that the supporting documentation that follows is Medicare modifier information and Facility Name and Address

MAN - Indicates that the supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address

MAR - Indicates that the supporting documentation that follows is Medicare modifier information and narrative information

MOD - Indicates that the supporting documentation that follows is Medicare modifier information

E. Misdirected Claims

Under the DMERC contract, a DMERC is required to forward claims to the appropriate DMERC for processing when it is determined that the claim submitted is for a beneficiary that resides in a state that is outside the receiving DMERC's processing area. These claims are referred to as "misdirected claims". When these claims are submitted in the NCPDP format they will be forwarded to the appropriate DMERC carrier in the NCPDP flat file format. These forwarded claims will not be re-translated. The NCPDP flat file format output will be produced by VMS, and it will be the responsibility of the DMERC that receives a misdirected claim to move it through the Medicare Data Communication Network (MDCN) to the appropriate DMERC. Misdirected claims must be subjected to all levels of editing by the original DMERC and rejected if found to be non-compliant. Only those claims that are determined to be HIPAA NCPDP format compliant will be forwarded.

40.3.1 - Electronic Remittance Advice

(Rev. 1, 10-01-03)

B3-3023.6, B3-3024.5, A3-3750, PM A-01-57, PM B-01-35

Remittance records must be provided to describe the claims for which payment is made.

- The FIs must provide the ANSI X12N 835 Transaction Set.

- Carriers must provide the ANSI X12N 835 Transaction Set and the NSF. The provider may select which to accept for the period prior to the implementation of HIPAA. Under HIPAA, only the 835 transaction set may be used.

Acceptable versions are published on the CMS Internet EDI Home page. ANSI X12N formats are used only via telecommunications. HIPAA version implementation guides may be downloaded without charge from http://www.wpc-edi.com/HIPAA, or users may phone 1-800-972-4334 to purchase hard copies.

40.3.2 - Standard Paper Remittance (SPR) Notices

(Rev. 1, 10-01-03)

PM A-01-57, PM B-01-76

By October 2003, shared systems must use the HIPAA version flat file, rather than any earlier flat file, to generate SPRs to avoid data variations between SPRs and ERAs in fields shared by both formats. Shared systems may change to use of the HIPAA version flat file for SPRs at any point after October 1, 2001, as long as completed by October 2003. Shared systems must furnish their FIs at least 90 days advance notice of their SPR changeover date. FIs must in turn furnish their SPR users with advance notice of the effective date of the change and any differences they can expect to see in their SPRs as result of the flat file changeover.

The Medicare core system will continue to record a maximum of 17 characters for patient account numbers. Patient account numbers in excess of 17 characters will be populated from the repository established for coordination of benefits for both SPRs and ERAs. If a provider requests a SPR or ERA after a 20-character patient account number has been purged from the repository, the SPR/ERA will report the first 17-characters only. A similar limitation applies to reporting of provider line item control numbers in ERAs.

All other data elements included in SPRs and ERAs will be populated from the Medicare core system. By as early as October 1, 2001, but no later than October 2003 shared systems must assure that all data elements that appear in both the SPR and the ERA for the same claim contain identical data. Fields shared by both formats for the same claim may not contain different data. As in the past, data not available in an ERA may not be reported in a SPR. SPRs will also be limited to reporting of one secondary payer, even when payment information for a claim is shared with more than one secondary payer under COB trading partners agreements.

40.3.3 - Remark Codes

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

AB-02-067, AB-02-142, AB-03-012

Carriers and FIs can download the currently approved remark code list from http://www.wpc-edi.com/codes/remittanceadvice for the currently approved, generically

worded remark code messages. These messages may be used in both pre-HIPAA and HIPAA format ERAs and standard paper remittances as soon as programming changes are complete. If carriers and FIs begin to use any of these codes for the first time, they must furnish advance notice to providers, including the code, the text, and under what situations the code will be used. Carriers, DMERCs, and FIs must use only currently valid codes available at the two Web sites mentioned above. CMS issues code update instruction every four months, informing of the changes made in the previous four months. In addition, contractors will be notified of new/modified codes that Medicare initiated in conjunction with a policy change, in the form of a PM or manual instruction implementing the policy change.

The use of "M" and "MA" codes was formerly restricted to line or claim levels. Any remark code may now be reported at either the claim or the line level, i.e., an "MA" code may now be reported in the LQ segment of the 835, and an "M" code in an MOA segment - if the wording of the message fits the situation being described at that level. "N" codes could always be reported at either the claim or the service level. All new remark codes will now begin with "N."

40.4 - Crossover Claim Requirements

(Rev. 831, Issued: 02-02-06; Effective: 07-01-06; Implementation: 07-03-06)

A. X12 837 COB

The outbound 837 COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data, as modified during adjudication if applicable, as well as payment data. Carriers, DMERCs, and FIs are required to accept all 837 segments and data elements permitted by those implementation guides on an initial 837 professional or institutional claim from a provider, but are not required to use every segment or data element for Medicare adjudication. Those supplemental segments and data elements must be retained, however, because they could be needed by a Medicare COB trading partner. The shared systems must maintain a store and forward repository (SFR) for retention of such supplemental data. Data must be subjected to standard syntax and applicable IG edits prior to being deposited in the SFR to assure non-compliant data are not included in COB transactions. SFR data must be reassociated with those data elements used in Medicare claim adjudication as well as with payment data in order to create an 837 IG-compliant outbound COB transaction. The shared systems must retain the data in the SFR for a minimum of 6 months.

The 837 version 4010A1 institutional and professional implementation guides require that claims submitted for secondary payment contain standard claim adjustment reason codes to explain adjudicative decisions made by the primary payer. For a secondary claim to be valid, the amount paid by the primary payer plus the amounts adjusted by the primary payer must equal the billed amount for the services in the claim. Although Medicare does not currently use adjustment information from a primary payer for other than Obligated to Accept payment in Full (OTAF) adjustments, a tertiary payer to which Medicare could forward the claim under a COB trading partner agreement could require

that data. A COB trading partner could reject a claim forwarded by Medicare if the adjustment and payment data from the primary payer or from Medicare did not balance against the billed amounts for the services and the claim. As a result, shared systems must reject inbound Medicare Secondary Payer claims if the paid and adjusted amounts do not equal the billed amounts at the line and claim level and if the claim lacks standard claim adjustment reason codes to identify the adjustments performed.

The shared system maintainers shall populate an outbound COB file as an 837 flat file with the Tax ID or SSN (for a sole practitioner) present in the provider's file, or in the case of an 837 flat file sent the COBC, present in each associated contractor's provider file. If no TaxID or SSN is available, the shared system(s) shall populate NM109 with syntactically compliant (all 9s if NM108 = '24' and '199999999' if NM108 = '34') data, pending availability of the billing provider's National Provider Identifier (NPI). Once the NPI is available, qualifier XX must be reported in NM108 and the NPI in NM109, and the taxpayer identification number reported in the REF segment of the billing provider loop. Prior to May 23, 2007, when an NPI is reported in NM109 for any of the types of providers for which data is included in a claim, Medicare will also send the legacy number (UPIN, National Supplier Clearinghouse or OSCAR) for each of those providers in the REF segment of the loop used to supply identifying information for that provider.

Contractors shall populate the outbound COB files with the provider's first name, last name, middle initial, address, city, state and zip code as contained in their provider files, in the event of any discrepancy with the inbound 837.

Each supplemental insurer specifies the types of claims it wants the carrier, DMERC, FI, or COBC to transfer. Examples of claims most frequently excluded from the crossover process are:

- Totally denied claims;
- Claims denied as duplicates or for missing information;
- Adjustment claims;
- MSP claims;
- Claims reimbursed at 100 percent; and
- Claims for dates of services outside the supplemental policy's effective and end dates.

On July 5, 2004, CMS began to transfer claim crossover responsibility from FIs, carriers and DMERCs to a national claims crossover contractor called the COBC. This initiative is titled as the "COB Agreement (COBA) Process." Under this process, carriers, DMERCs and FIs will be sent a CWF Beneficiary Other Insurance (BOI) auxiliary reply trailer that a trading partner has selected a beneficiary's claim for crossover. Upon receipt of a BOI reply trailer, the FI, carrier, or DMERC will transfer the processed claim to the COBC as an 837 COB flat file or NCPDP file to be crossed over to the trading

partner. Refer to Chapter 28, section 70.6 of the Claims Processing Manual for further details about specific carrier, DMERC, and FI responsibilities under the COBA process.

The translator used by a carrier, DMERC, FI, and the COBC will build the outbound 837 COB transaction from the flat file data supplied by that contractor's shared system.

Until all trading partners are moved into cross-over production with the COBC, non-transitioned supplemental insurers/payers will continue to provide an eligibility file no less frequently than monthly, preferably weekly, to enable Medicare contractors to identify dually eligible individuals whose claims are to be forwarded for COB/crossover purposes. In addition, until all trading partners are moved into production with the COBC, Medicare contractors shall continue to send COB transactions to their trading partners at least once a week. Pending completion of the transition to the COBC, carriers, DMERCs, and FIs may transmit COB data to a trading partner in either the HIPAA 837 version 4010A1 format or in a legacy format, according to the trading partner's preference. Upon the earlier of the completion of the COB transition or termination of the Medicare outbound COB claim contingency plan, COB transactions may be sent to trading partners only in the X12 837 version 4010A1 format.

The HIPAA implementation guides (IGs) state that the ISA08 is an "identification code published by the receiver of the data; when sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them." The ISA08 is a 15-position alphanumeric data element. FIs, carriers, and DMERCs, and their shared systems must populate 15 positions of ISA08 data (as published by the receiver of the data) on outbound X12N HIPAA transactions. FIs, carriers, DMERCs, and the COBC must also make the necessary changes to be able to ensure that each trading partner has a unique ISA08. FIs, carriers, DMERCs, and the COBC must inform their trading partners that the CMS cannot allow two trading partners to have the same ISA08.

HIPAA required that any payer that conducts electronic COB transactions for other than retail pharmacy drug claims use the X12 837 version 4010A1 format for COB by October 16, 2003 (subsequently extended by the ASCA extension request process and the Medicare HIPAA contingency period). HIPAA did not give payers the option to exclude claims received on paper or received in a pre-HIPAA electronic format from compliancy requirements for X12 837 version 4010A1 COB transactions. An inbound claim received on paper or in a non-version 4010A1 electronic format could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum or maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound X12 837 COB transaction, however. Paper and earlier electronic claim formats do not contain as many data requirements as the claim versions adopted as the national standard under HIPAA.

In most cases, electronic claims received with invalid data are rejected, but in limited cases such as for a claim received on paper or in a legacy electronic format, a claim could be accepted and adjudicated that lacks one or more pieces of data needed for a HIPAA-compliant COB transaction. It is also possible to receive invalid data from the Medicare

Common Working File (CWF) database. For example, a State abbreviation in an address transferred from the Social Security Administration (SSA) for Medicare enrollment might contain one letter rather than two in the State abbreviation. A one letter State abbreviation violates the X12 requirements that two letters appear in a State abbreviation, but due to the Medicare prohibition against modification of beneficiary addresses supplied by SSA, the shared system is left with a dilemma. Such errors cannot be corrected unless the beneficiary contacts SSA and requests correction. This is not a priority for many beneficiaries since they receive their SSA payments electronically.

To resolve this problem for COB, the shared system must "gap fill" data in certain cases when issuing flat file data for carrier, DMERC, or FI translation into a HIPAA-compliant COB transaction. If data elements are unavailable or incomplete, but are needed to prepare a HIPAA-compliant COB transaction, the shared system must "gap fill."

When non-HIPAA inbound claims do not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the shared systems maintainers (other than MCS) and the carriers that use MCS shall gap fill alphanumeric data elements with Xs and numeric data elements with 9s. For example, a 5-character alphanumeric data element would contain "XXXXX" and a 5-character numeric data element would contain "99999".

When non-HIPAA inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12 837 HIPAA COB transaction, the shared system maintainers (other than MCS) and MCS Carriers shall gap fill the phone number data element with "8009999999".

Data elements with pre-defined IG values such as qualifiers, and data elements that refer to a valid code source shall not be gap filled. Paper claims do not usually contain qualifiers but do contain explicit field names that provide information equivalent to qualifiers or that identify valid code sources. For COB purposes, those field names must be mapped to the appropriate qualifier or code source for reporting to trading partners in the 837 version 4010A1 format.

Until trading partners are fully moved into production with the COBC, carriers, DMERCs, FIs are required to notify their COB trading partners of the common situations when gap filling could occur and of the characters that will be used to gap fill according to data type of the particular X12 data element.

B. NCPDP COB Transaction

The NCPDP has approved the following use of qualifiers in the Other Payer Paid Amount field for reporting Medicare COB amounts:

"07" = Medicare Allowed Amount

"08" = Medicare Paid Amount

"99" = Deductible Amount

"99" = Coinsurance Amount

"99" = Co-Payment Amount

NOTE: The first occurrence of "99" will indicate the Deductible Amount.

The second occurrence of "99" will indicate the Coinsurance Amount.

The third occurrence "99" will indicate the Co-Payment Amount.

C. Legacy Formats

Prior to implementation of the NCPDP standard in compliance with HIPAA, retail pharmacies were required to use the CMS-1500, NSF, or X12 837 format to bill drugs covered by Medicare Part B to DMERCs. See §40.2 for information on the legacy formats that can be used in lieu of the NCPDP format pending termination of the Medicare COB claim contingency plan.

40.4.1 - Payment Floor Requirement

(Rev. 1, 10-01-03)

A3-3600.1 - partial, A1-1430, B3-4430

Carriers and FIs must transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim. They must designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

40.4.2 - Alternative to EFT

(Rev. 1, 10-01-03)

A3-3600.1 - partial, A1-1430, B3-4430

The only acceptable alternative to EFT is paper check mailed by first class mail.

40.4.3 - Tri-Partite Bank Agreement

(Rev. 1, 10-01-03)

A3-3600.1 - partial, 1430, B3-4430

The FIs and carriers must ensure that Tri-partite bank agreements (three-party agreements between the contractor, the bank, and the provider) include wording that allows funding of the letter of credit to include EFT as well as paper checks. The agreement must clearly state that all references to checks in the agreement include checks and/or electronic funds transfer.

For more information, refer to the Medicare Financial Management Manual, Pub. 100-06, Chapter 5.

40.5 - Direct Data Entry (DDE) Screens

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

HIPAA does not require, but does permit payers to maintain DDE screens for claim submission, correction, claim status determination, and eligibility verification. Medicare FIs are required to maintain claim submission, claim correction and claim status screens, but not Medicare carriers or DMERCs. (See chapter 31 for eligibility verification DDE requirements.)

Medicare considers transactions conducted via DDE screens to meet HIPAA-compliancy requirements. DDE claims are considered HIPAA-compliant EDI transactions for application of the 14-day payment floor. (See §70.2.B of this chapter for further FI DDE information.)

Data entered via DDE screens are not subject to the syntax (format) requirements of the standards, but must meet "applicable data content" requirements for comparable HIPAA transactions. FIs may continue to use existing DDE screens for claim corrections since this function is not subject to HIPAA. DDE systems are proprietary by definition. They are a direct link between a particular health plan (Medicare) and its providers, and the software (and sometimes hardware) is unique to and maintained by the plan. The widespread use of the standard HIPAA transactions should make it economically feasible for more providers to procure or develop their own EDI products that can be used with all plans. The use of DDE should decrease over time as a result. The requirement for "applicable data content" is meant to facilitate that eventual conversion. Adopting the data content requirements of HIPAA in DDE screens will facilitate eventual migration of providers from DDE to use of EDI transaction software (or to use of a clearinghouse). This will also permit maintenance of DDE-generated data and HIPAA standard transaction-generated data in the same databases.

In this context, "applicable data content" means shared system-maintained DDE screens and the CWF maintainer eligibility screens must:

- Collect all data elements that are required in the IG as well as those situational elements that are needed for Medicare processing (unless the data is already available to the payer's system);

- Use only the internal and external code sets designated in the IG with no additions or substitutions;

- Provide for at least the field size minimums noted in the IG, but no more than the maximum sizes (Do not expand the size of a shared system's internal claim records);

- Permit at least the minimum number of field repeats noted in the IG, but no more than the maximum number;

- Allow for only one investigational device exemption number (IDE) per claim (at the claim level);

- Remove employment status code, employer name, and employer address information;

- Allow Other Subscriber Demographic Information (date of birth and gender) if the other subscriber is a person;

- Allow for discharge hour and minute information in the numeric form of HHMM; and

- Allow for correct processing of the unique physicians identifier number in the 2310A (Attending Physician) loop.

Data elements not used by-Medicare are not currently collected in Medicare DDE screens. Claims correction via DDE should be limited to Medicare data (non-Medicare data in error should be purged with an appropriate error message to the DDE user). With Medicare data plus some information from shared system files, an IG compliant COB transaction can be written.

NOTE: See section 70.2.B for additional DDE edit requirements.

40.6 - Use of Imaging, External Key Shop, and In-House Keying for Entry of Transaction Data Submitted on Paper

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

At one time, all imaged claims, and claims entered via external key shops or in-house contractor staff members were produced only in the NSF or UB-92 flat file format. In anticipation of termination of the Medicare incoming claim HIPAA contingency plan, carriers, DMERCs, and FIs were to convert their output from their imaging and external key shops into the 837 institutional and professional claims flat files to enable continued processing by the shared systems by October 1, 2004. Carriers, DMERCs, and FIs must bypass IG edits that do not apply to claims received on paper since paper claims are not required to comply with X12 837 segment and data element requirements.

40.7 – Electronic Funds Transfer (EFT)

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Although EFT is not mandated by HIPAA, EFT is the preferred method of Medicare payment. Carriers, DMERCs, and FIs must obtain and retain a signed copy of Form CMS-588, Authorization Agreement for Electronic Funds Transfer, from each provider that elects use of EFT. Carriers, DMERCs, and FIs may not require providers that elect

EFT, but have not elected to use any other EDI transactions, to complete an EDI Enrollment Form. If the provider declines to accept electronic deposit to a bank account, the carrier, DMERC, or FI should attempt to convince the provider to accept direct deposit via EFT by discussing the benefits of EFT, e.g., faster payment, easier payment reconciliation.

Provider pick-up of Medicare checks, next day delivery, express mail, and courier services are not allowed except in special situations authorized by the CMS RO. EFT is the fastest means of Medicare payment. The only acceptable alternative to EFT is a paper check mailed by first class mail. See the Medicare Financial Management Manual, Pub. 100-06, Chapter 5, §160 for further information on EFT.

An FI, carrier, or DMERC must use a transmission format that is both economical and compatible with the servicing bank. Normally this will be either the National Automated Clearinghouse Association (NACHA) format, or the X12 835 format. (Table 1 of the 835 can also be used to trigger EFT payment.) Carriers, DMERCs, and FIs must transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim. They must designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

40.7.1 – X12N 837 Institutional Implementation Guide (IG) Edits

(Rev. 238, Issued 07-23-04, Effective: 01-01 05, Implementation: 01-03-05)

The FI shared system shall edit (via an edit module run by the FI) outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims, TOBs 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X claims to ensure each contains a line item date of service (LIDOS) for each revenue code. Outpatient claims not containing a LIDOS for each revenue code shall be rejected from the flat file with an appropriate error message.

The FI shared system shall edit outpatient claims submitted via direct data entry (DDE) to ensure each contains a LIDOS for each revenue code. Any outpatient claims found without a LIDOS for each revenue code shall be subject to an appropriate on-line error message.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. These claims containing an ICD-9 procedure shall be rejected by the shared system with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all outpatient claims to ensure all Health Insurance Prospective Payment System (HIPPS) Rate Codes used with a "ZZ" qualifier are accepted (not just HIPPS skilled nursing facility rate codes).

The FI shared system shall edit all outpatient claims to ensure each does not contain Covered Days (QTY Segment). Outpatient claims containing Covered Days shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit outpatient claims submitted via DDE to ensure all occurrences of the data element do not contain Covered Days. Any outpatient claims submitted via DDE containing Covered Days shall be subject to an appropriate on-line error message.

The FI shared system shall edit all claims to ensure each does not contain a NPP000 UPIN. Claims containing a NPP000 UPIN shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all claims submitted via DDE to ensure each does not contain a NPP000 UPIN. Any claims submitted via DDE containing a NPP000 UPIN shall be subject to an appropriate on-line error message.

For the outbound X12N 837 HIPAA COB transaction, the FI shared system shall edit all claims to ensure each containing service line adjudication information also contains an appropriate service line adjudication date (the paid claim date).

The FI shared system shall edit all claims to ensure each does not contain an invalid E-code. Claims containing an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims found containing an invalid E-code shall be subject to an appropriate on-line error message.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid diagnosis code (a diagnosis code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid condition code (a condition code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid value code (a value code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid occurrence code (an occurrence code not listed in the external code source referenced by the HIPAA 837 institutional IG), or an invalid occurrence span code (an occurrence span code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims submitted via DDE containing an invalid E-code, condition code, value code, diagnosis code, occurrence code, or occurrence span code shall be subject to an appropriate on-line error message.

The FI shared system shall edit outpatient claims received via DDE to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any outpatient claim found containing an ICD-9 procedure code shall be subject to an appropriate on-line error message.

The FI shared system shall edit outpatient HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid E-code, condition code, value code, occurrence code, or occurrence span code. These shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The healthcare provider taxonomy codes (HPTCs) must be loaded by the FIs and FI shared system, as contractor-controlled table data, rather than hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future updates. The HPTCs are scheduled for update 2 times per year (tentatively October and April). That list may be downloaded in portable document format (PDF) from the Washington Publishing Company (WPC) for no charge or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. Use the most cost effective means to obtain the list for validation programming and updating purposes.

The FIs and FI shared system shall edit all claims to ensure that HPTCs that have been submitted comply with both the data attributes for the data element as contained in the HIPAA 837 institutional IG, and are contained in the approved list of HPTCs. HPTCs are not required data elements. Claims received with invalid HPTCs shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all outpatient claims to ensure each containing revenue code 045X, 0516, or 0526 also contain an HI02-1 code of “ZZ”, along with a compliant “Patient Reason for Visit” diagnosis code. Outpatient claims containing an invalid “Patient Reason for Visit” code (a “Patient Reason for Visit” code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

For the outbound HIPAA X12N 837 COB transaction, the FI shared system shall ensure a “ZZ” qualifier in HI02-1 is populated when revenue code 045X, 0516, or 0526 is present on an outpatient claim.

For bill types 12X and 22X, FIs and FI shared system shall be responsible for editing to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present on an inbound 837 (contractors should already be editing other inpatient bill types to ensure these are required). Claims not containing this data shall be rejected from the flat file with an appropriate error message before the flat file is accepted by the shared system.

For bill types 12X and 22X, the FI shared system shall edit to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code

are present when submitted via DDE (these are already required for other inpatient bill types). Claims not containing this data shall be subject to an appropriate on-line error message.

40.7.2 – X12N 837 Professional Implementation Guide (IG) Edits

(Rev. 86, 02-06-04)

The Part B carriers and durable medical equipment regional carriers (DMERCs) must reject inbound electronic claims that contain invalid diagnosis codes whether pointed to a specific detail line or not.

The Part B carriers and DMERCs shall reject inbound electronic claims that contain a space, dash, special character, or 1 byte numeric in any zip code.

The Part B carriers and DMERCs must reject inbound electronic claims that contain a space, dash, special character, or parentheses in any telephone number.

40.7.3 – National Council for Prescription Drug Program (NCPDP) Implementation

(Rev. 84, 02-06-04)

A. NCPDP Implementation Guide (IG) Edits

The DMERCs must allow segments to be submitted in any order including the AM07, AM03 and AM11 according to the NCPDP standard.

B. NCPDP Narrative Portion of Prior Authorization Segment

The DMERCs must allow the value "MOD" to be entered in positions 001-003 of the narrative portion of the prior authorization segment indicating that the supporting documentation that follows is Medicare modifier information.

50 - EDI Testing Requirements

(Rev. 615, Issued: 07-22-05, Effective/Implementation Dates: 10-01-05)

50.1 - Shared System and Common Working File (CWF) Maintainers Internal Testing Requirements

(Rev. 615, Issued: 07-22-05, Effective/Implementation Dates: 10-01-05)

Shared system and CWF maintainers, and their beta testers where appointed, must test shared system releases that include modifications affecting EDI transactions prior to issuance of those releases, unless specific waivers are granted by the CMS. The CWF maintainer's involvement in EDI is limited to programming related to the electronic eligibility transaction. Shared system and CWF maintainers and beta testers must support

a testing environment that simulates the production environment as closely as possible. The shared system maintainers must implement system changes to enable carriers, DMERCs, and FIs to conduct automated tests with EDI submitters/receivers of the HIPAA versions of the standard transactions at the same time that submitters/receivers are using an earlier version of a transaction in production.

50.2 - Carrier, DMERC, and FI Internal Testing Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, FIs, and/or their data centers must successfully complete testing of shared system releases that impact their front or back end processing prior to use of that programming in production, or to test with potential users of the transactions. Release testing requirements and completion dates are contained in specific shared system release instructions. Carriers, DMERCs and FIs must use a translator to convert standard data into the flat file format processed by the shared system and to convert flat file data into compliant outbound HIPAA transactions.

Carriers, DMERCs, and FIs must test the effectiveness of their translator, including the syntax editing performed by their translator at the front (incoming transactions) and back (outgoing transactions) ends and any IG level editing if performed by their translator, and to test the effectiveness of those inbound and outbound semantic IG edits they (carrier, DMERC, and to the extent performed by FIs) may use at their front and/or back ends to ensure that both inbound and outbound transactions comply with the standards and the appropriate IGs. Shared system maintainers are responsible for inclusion of all data elements in their flat file that carriers, DMERCs, and FIs require to translate the flat file data into a compliant outbound transaction. Shared systems are also responsible for testing of the effectiveness of those inbound and outbound semantic edits used during the shared system phase of processing.

IG semantic edits test compliance with IG-specific requirements, which may differ in some cases from the underlying standard. For example, a segment or data element identified as optional in the standard may be required in an IG. In addition, an IG indicates which qualifiers and codes are permissible in a transaction, while the standard requirements do not include that level of detail. An invalid code could actually be accepted at the standard level but would be rejected at the IG level. Carrier and DMERC shared system maintainers are responsible for application of IG semantic edits for incoming transactions, and individual carriers and DMERCs are responsible for preparation of IG compliant outbound transactions. Individual FIs are responsible for application of some IG semantic edits prior to transfer of data to their shared system for processing and preparation of IG compliant outbound transactions, and FISS is responsible for application of all other required IG semantic edits. In some cases, individual FIs have separately contracted with their data center to serve as their front and/or back end for receipt or issuance of electronic transactions. In those cases, the data center tests and applies the appropriate institutional syntax and semantic IG edits. The Fiscal Intermediary Shared System (FISS) also performs additional IG editing on behalf

of FIs that have a license for use of a version of the Mercator translator supported by FISS.

50.3 - Third-Party Certification Systems and Services

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

There are a number of third-party HIPAA certification systems that market test data and testing services to evaluate a user's compliance with the IG requirements for the HIPAA transaction standards. CMS does not require that submitters/receivers of HIPAA transactions obtain such certification. CMS adopted the national Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Testing Sub-workgroup's recommendations on the levels of testing (syntax, semantic and application edits) to foster greater testing uniformity within the health care industry overall. More information on the WEDI testing levels is available at www.wedi.org. If a billing service, clearinghouse, or software vendor notifies a carrier, DMERC, or FI that they have successfully tested with an independent HIPAA transactions compliance evaluation company at WEDI levels 1 and 2 at a minimum, and can provide a certificate from that company or the web address where the company identified this party as having passed WEDI level 1 and 2 testing, carriers, DMERCs, and FIs have the option to waive testing of the entities that received such certification.

50.4 - EDI Submitter/Receiver Testing by Carriers, DMERCs, and FIs

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs are required to pre-test submitters planning to use X12 837 version 4010A1 and/or the NCPDP HIPAA claim format to assess system and data compatibility and compliancy prior to submission of "live" electronic claims in those versions for adjudication, except as waived in sections 50.3 and 50.4.1. A "submitter" is the entity that actually transmits transaction data to Medicare, such as a provider or billing agent that transmits to Medicare directly via a modem or other telecommunication connection, or a clearinghouse that may transmit to Medicare on behalf of many providers or billing agents. Carriers, DMERCs, and FIs are not required to pretest submitters or receivers of other EDI formats (835, 276/277, 270/271) adopted under HIPAA, unless requested to do so by a submitter/receiver or the submitter/receiver has never previously used EDI for Medicare transactions. A "receiver" is the entity to which an outbound transaction is sent by a carrier, DMERC, or FI.

Carriers, DMERCs and FIs were required to begin scheduling testing of X12 837 version 4010A1 claim submitters by April 1, 2003, unless given an extension by CMS due to a pending transition to an alternate shared system, such as the APASS to FISS transition or due to some temporary local problem. Carriers, DMERCs, and FIs were to complete that testing by October 16, 2003 (now extended until the end of the contingency period). Carriers, DMERCs, and FIs are not required to retest electronic claim submitters that successfully tested the X12 837 version 4010 claims transaction standard on version 4010A1 unless specifically requested by those users, or the carrier, DMERC, and/or FI

considers 4010A1 testing to be advisable to avoid potential later problems. Until further notice, pending a decision to terminate the contingency period, carriers, DMERCs, and FIs are to continue to accept claims submitted in pre-HIPAA electronic formats from providers, billing agents, and clearinghouses that have not yet successfully completed testing of the HIPAA claim format(s) and had previously been approved to submit claims transactions in a legacy format.

50.4.1 - Testing Accuracy

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

All claim submitters must produce accurate electronic test claims before allowed to submit HIPAA format claim transactions in production. All submitters must send the carrier, DMERC, or FI a test file containing at least 25 claims, which are representative of their practice or services. Carriers, DMERCs, or FIs may, based on individual consideration, increase or decrease the number of claims required to adequately test any given submitter. Carriers, DMERCs, or FIs will subject test claims to standard syntax and IG semantic data edits and will provide documentation when edits detect errors.

- Standard syntax testing validates the programming of the incoming file and includes file layout, record sequencing, balancing, alpha-numeric/numeric/date file conventions, field values, and relational edits. Test files must pass 100 percent of the standard syntax edits before production is approved.

- IG Semantic Data testing validates data required for claims processing, e.g., procedure/diagnosis codes, modifiers. A submitter must demonstrate, at a minimum, a 95 percent accuracy rate in data testing before production is approved where, in the judgment of the carrier, DMERC, or FI, the vendor/submitter will make the necessary correction(s) prior to submitting a production file. For FIs, the minimum 95 percent accuracy rate includes the front-end edits applied using the FISS implementation guide editing module.

Carriers, DMERCs, and FIs must provide test results to the submitter within three (3) business days (use the computation method contained in Chapter 1 of this manual for determination of the age of a claim to compute the number of elapsed days).

50.4.2 – Limitation on Testing of Multiple Providers that Use the Same Clearinghouse, Billing Service, or Vendor Software

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Many claim submitters use the same software, or the same clearinghouse to submit their electronic claims to Medicare. In those cases, carriers, DMERCs, and FIs are not required to test each submitter that uses the same software, or each provider or billing agent that uses the same clearinghouse. Carriers, DMERCs, and FIs may require potential third party submitters to have an approved Medicare provider as a client prior to testing with such third parties, however. It is sufficient to test with a small number of users of the same software to establish that the software is compliant, or to simply test

with a single provider using a clearinghouse to establish the compliancy of the clearinghouse's software and connectivity for transmission of claims data. Likewise, once carriers, DMERCs, and FIs have tested the validity of the free/at cost billing software they distribute on request, the carriers, DMERCs, and FIs are not expected to test providers that have elected to use that billing software.

Health care providers that submit transactions directly to more than one Medicare carrier, DMERC, and/or FI, and billing services and clearinghouses that submit transactions to more than one Medicare carrier, DMERC, and/or FI, must contact each carrier, DMERC, and/or FI with whom they exchange EDI transactions to inquire about the need for supplemental testing whenever they plan to begin to use an additional EDI transaction, different or significantly modified software for submission of a previously used EDI transaction, or before a billing agent or clearinghouse begins to submit transactions on behalf of an additional provider. Carriers, DMERCs, and/or FIs may need to retest at that time to re-establish compatibility and accuracy, particularly if there will also be a change in the telecommunication connection to be used.

Billing services and clearinghouses are not permitted to begin to submit or receive EDI transactions on behalf of a provider prior to submission of written authorization by the provider that the billing agent or clearinghouse has been authorized to handle those transactions on the provider's behalf. See section 20 of this Chapter for further information on EDI Enrollment.

50.4.3 – Carrier, DMERC, and FI Submitter/Receiver Testing with Legacy Formats during the HIPAA Contingency Period

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Providers, their billing agents, or clearinghouses that contact a carrier, DMERC, or FI to request testing for submission or receipt of electronic transactions for the first time are required to test in a HIPAA format for any EDI transaction, other than eligibility verification, even if they propose use of vendor software currently being used by other providers that are allowed to temporarily submit electronic transactions in a legacy format. Carriers, DMERCs, and FIs may not test "first time" users of any transaction other than eligibility verification (pending CMS announcement of the termination of the Medicare HIPAA 270/271 contingency plan) in a legacy format.

During the contingency period, providers, their billing agents, and clearinghouses are required to make a good faith effort to complete transition to the HIPAA transaction formats as soon as possible. It would be counterproductive and not cost effective for carriers, DMERCs, and FIs to test on both legacy and HIPAA formats in this situation. Nor is it considered cost effective for new providers, billing agents, or clearinghouses to test for the first time at this point on any legacy electronic formats as they would be required to reprogram and retest prior to the end of the contingency period for use of the HIPAA adopted transaction standards.

New physicians that join an existing group practice that still uses a legacy format are permitted to submit electronic transactions in that legacy format and are not considered "new" providers for application of the ban against addition of new providers for use of legacy formats. New physicians hired by an existing group become part of that group, and transactions for group members are submitted under the number for the group rather than under the individual number of the group physician who normally treats a patient.

50.4.4 - Discontinuation of Use of COB Claim Legacy Formats Following Successful HIPAA Format Testing

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Transmission of pre-HIPAA electronic format claims to other payers under a COB agreement will end the earliest of the date that:

1. A trading partner completes successful testing on use of the X12 837 version 4010A1 and/or the HIPAA NCPDP format (as appropriate); or

2. The Medicare HIPAA COB contingency plan ends.

* At the current time, none of the COB trading partners are willing to accept NCPDP format transmissions for secondary payment due to the lack of data elements in that format for reporting of a number of data elements required for computation of benefits by the secondary payer. CMS is working with the NCPDP to develop a "workaround" to resolve this problem. Pending release of such a "workaround", NCPDP claims will not be crossed over to other payers. Retail pharmacies will need to bill secondary payers directly to collect supplemental benefits that may be due for those claims.

50.4.5 - EDI Receiver Testing by Carriers, DMERCs, and Intermediaries

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Carriers, DMERCs and FIs are not required to test individuals who request use of outbound electronic remittance advice (ERA) or claim status transactions unless parties that request receipt of those transactions request pre-testing prior to production use of one or more of those outbound transactions. Carriers, DMERCs, and FIs may, at their discretion, require pre-production testing of outbound transactions if there is concern that specific receivers could otherwise experience significant problems. Carriers, DMERCs, and FIs that did test successfully with certain receivers on version 4010 of the 837 for COB or the 835 are not required to retest on version 4010A1 unless requested by a receiver. 837 COB testing is required with those trading partners prior to transmission of live COB data in the 837 version 4010A1. Even if testing is not normally required, parties that want to begin receipt of an outgoing transaction supported by Medicare must notify their Medicare carrier, DMERC, and/or FI when to begin transmission of the HIPAA version of a specific outgoing transaction.

Terminate transmission of ERAs to those receivers that have not notified you they are able to accept and process X12 835 version 4010A1 transactions by the end of the Medicare contingency period. Also terminate transmission of COB transactions to trading partners that have not successfully tested with you for receipt of the X12 837 version 4010A1 by the end of that contingency period. Likewise, no pre-HIPAA 271 or legacy format electronic claim status EDI responses may be issued after the date when the Medicare contingency plan ends for that transaction type. See Chapter 31 for specific information concerning electronic claim status and eligibility transactions. Terminate issuance of version 4010 X12 277 transactions and acceptance of version 4010 X12 276 transactions when that contingency plan is terminated.

50.5 - Changes in Provider's System or Vendor's Software and Use of Additional EDI Formats

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Health care providers that receive or send transactions directly from/to more than one Medicare carrier, DMERC, and/or FI, and billing services and clearinghouses that receive or send transactions from/to more than one Medicare carrier, DMERC, and/or FI, must contact each carrier, DMERC, and/or FI with which they receive/send EDI transactions to inquire about the need for supplemental testing whenever they plan to begin to use an additional type of EDI transaction. A provider must also notify their Medicare carrier, DMERC, or FI in writing (see EDI enrollment in §20 of this chapter) if they will begin to use a billing agent or clearinghouse for the first time, change a billing agent or clearinghouse, discontinue use of any billing agent or clearinghouse, or authorize a billing agent or clearinghouse currently used for some transactions to begin receiving additional transactions. A billing agent or clearinghouse representative is prohibited from signing an authorization on behalf of a provider to allow them to act as the sender or receiver of specific EDI transactions on behalf of a provider, even if a provider has signed a contract with the billing agent or clearinghouse for such services.

60 - Support of EDI Trading Partners

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

60.1 - User Guidelines

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carrier, DMERCs, and FIs must make information available to potential users (preferably via their Web page or the Internet) of each EDI transaction supported by Medicare with detailed information on:

- The telephone numbers of appropriate staff to contact to:
    - Get started with electronic billing and other EDI transactions; and

- Obtain on-going support for electronic transactions.

- Testing requirements and the submitter's and carrier, DMERC, or FI's level of responsibility throughout each step of the testing process (see §30);

- The availability of the appropriate specifications for this provider and instructions for accessing these via the Internet or other cost effective means;

- The availability of the carrier, DMERC, or FI's provider bulletins via the Internet and/or bulletin board system;

- The availability of the carrier, DMERC, or FI's EDI instructions or procedures via the Internet and/or bulletin board system;

- The availability of the carrier, DMERC, or FI's free Medicare EMC software and the FIs free PC-Print software (PC-Print software for carriers expected to be issued in October 2005) upon request;

- Login requirements;

- Hours of operation, system and support;

- Telecommunication options and requirements;

- Procedures for updating submitters with any billing changes;

- EDI formats required for input to the carrier, DMERC, or FI's system. These specifications must be in sufficient detail for the submitter's use, and must include information regarding code, record length(s), field positioning within record(s), labeling and any other conventions necessary for compatibility with the carrier's, DMERC's or FI's system;

- All acceptance and rejection formats and content for output from the carrier, DMERC, or FI's system that will be returned to the submitter;

- Special instructions related to specific diagnosis or procedure codes, i.e., the necessity for attachments or modifiers and appropriate placement within the electronic record;

- Availability of online claim entry, claim correction (FIs only), claim status check, eligibility verification, claim development via DDE or otherwise, and the procedure for accessing these transactions;

- Specifications of the carrier, DMERC, or FI's front-end editing process (except in those cases when disclosure of specific edits is related to medical (Review or another sensitive area for which disclosure is not advisable) with complete list of error codes and resolution, including those conditions that will result in the rejection of entire EDI transmissions/batches;

- Conventions for acknowledging claims received and for recovering data known to be lost;

- Instructions for submitters to notify their carrier, DMERC, or FI of changes to the submitter profile in regard to use of clearinghouses, billing agents, EDI transactions and software for submission/receipt of those transactions;

- Carrier, DMERC, and FI listings of vendors and clearinghouses that are approved for production;

- Data requirements for reporting third party payers, i.e., Medigap, crossover, Medical Assistance and private insurance; and

- Frequently asked questions and answers about EDI.

60.2 - Technical Assistance to EDI Trading Partners

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs will provide help desk support to assist submitters and receivers with inquiries related to file transmission and acknowledgment, file retrieval, transaction requirements/specifications and the use of free software. Help desk support will be available during normal business hours at a minimum. Time zone differences at the provider's location should be accommodated if possible. Help desk activities are to be controlled and monitored through an automated call management system that provides the following functions:

- Control (login) of all incoming calls: identification of caller, reason for call, date and time;

- Track activities related to the call to the final resolution of the call: identification of routing, callbacks, issues, and resolution;

- Workload distribution of open items;

- Classification of call types for resource planning, provider education, management reporting; and

- Storage of caller-specific audit trails.

In addition to an automated call system, FIs, carriers and DMERCs must provide for receipt of e-mail, voice mail, or fax when the help desk is not available. Receipt of customer service inquiries must be acknowledged within one business day, or attempts to acknowledge the inquiry within this time must be documented if contact has not been made successfully.

Where transmission, retrieval or file problems are reported, a plan of action to resolve the issue must be provided to the inquirer within three (3) business days. This plan should include one or more of the following:

- An indication that the carrier, DMERC, or FI looked into the issue and did not identify a problem;
- The submission of a new corrected file;
- An explanation which either solves the problem or indicates action which the submitter or receiver can take to resolve the problem;
- An indication of the need for further investigation, with an estimated time frame for responding with more information and or a resolution;
- An indication that resolution requires carrier, DMERC, or FI action, and a description of the plan for resolution and estimated completion date.

Where the problem affects multiple submitters the carrier, DMERC, or FI make information on the issue available to all affected submitters.

60.3 - Training Content and Frequency

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

See the CMS Provider Education and Training (PET) manual for the definitive provider outreach and training requirements. Provider training is included in the CMS contractor PET budget and although EDI information must be included in those training efforts as appropriate, the PET requirements contain specific activities that must be completed by carriers, DMERCs, and FIs. When possible, EDI training should be conducted in conjunction with non-EDI training to share training room and trainers' expenses. This EDI-related training information is included in Chapter 24 for reference purposes only. Where appropriate, carriers, DMERCs, or FIs may develop user groups for general EDI users and free software users. Medicare carriers, DMERCs, or FIs are not required to support or train providers on the use of software provided by commercial vendors/trading partners, on X12 format structure or coding, the use of PCs, or other subjects non-specific to Medicare EDI. On an ongoing basis, carriers, DMERCs, and FIs should assess the need for additional training based on:

- Periodic identification and evaluation of common electronic billing errors;
- New software release; or
- The introduction of new EDI functions or changes to existing functions.

60.4 - Prohibition Against Requiring Use of Proprietary Software or DDE

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs will accept and process transactions created from any software as long as the transactions comply with the IG requirements adopted under HIPAA (refer to §40) and CMS requirements. Carriers, DMERCs, and FIs are prohibited from requiring that submitters of EDI transactions use proprietary billing software or specific hardware either before or after expiration of the HIPAA contingency period. Carriers, DMERCs, and FIs may not charge providers that use their own software, hardware, modems, and telecommunication lines to submit and/or receive electronic transactions in a HIPAA-compliant format.

DDE screens generally involve the use of dumb terminals programmed for specific uses, or of PCs that use software issued by a payer to emulate a dumb terminal to permit providers to individually enter claim data and correct claims errors (applies to Medicare institutional claims only), verify beneficiary eligibility (FIs and some carriers), obtain claims status (FIs and some carriers), or possibly perform another function. Since carriers, DMERCs, and FIs incur additional costs to maintain DDE functionality and support, they are allowed to recoup those costs from users and are permitted to charge a reasonable amount for its use. Carriers, DMERCs, and FIs may not require use of DDE, or refuse to accept or discourage submissions of transactions submitted in HIPAA compliant standards.

60.5 - Free Claim Submission Software

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Carriers, DMERCs, and FIs will make available software for their providers that is designed for use on a Windows-based PC for submission of claims to Medicare electronically. This software must also be able to identify when Medicare is a secondary payer and to collect data elements concerning a primary payer's payment, standard claim adjustment reason codes and adjustment amounts made by a primary payer prior to submission of a claim to Medicare for secondary payment.

The software is free but carriers, DMERCs, and FIs may charge a fee up to $25.00 per release to recoup their postage, reproduction, and handling expenses when a provider requests the software be sent via diskette, CD, or other medium, rather than downloaded by a provider from the Medicare contractor's Web page (if not precluded by a software copyright or licensing agreement). FIs, carriers, and, DMERCs were to complete upgrades to their free/at cost billing software to correspond to the requirements of the version 4010A1 X12 837 IG prior to October 16, 2003, and upgrade that software as necessary by October 1, 2004, to enable collection of other payer data. Claims submitted with that software are considered to be HIPAA-compliant. Whenever carriers, DMERCs, and FIs issue a new version of their free billing software, they shall notify providers to terminate use of the earlier version of the Medicare free billing software within 90-days of release of the updated software.

FIs, carriers, and DMERCs are not funded to issue free/at cost software for submissions of NCPDP claims or for any other type of inbound HIPAA transaction. Testimony

presented on the NCPDP format when proposed as the HIPAA retail pharmacy drug format indicated that such software was already in widespread use by retail pharmacies and that there was not a need for Medicare to fund development of free billing software for retail pharmacies.

Prior to distributing the initial or updated versions, carriers, DMERCs, and FIs will scan the free billing software with a current anti-virus program. This basic software must, at a minimum, contain the following:

- Edits to prevent incomplete and inaccurate claims from entering the system;
- "User friendly" qualities including:
  - A low initial investment, as well as low-cost upgrades, on the part of the submitter;
  - Minimal effort for both the software installation and training for the submitter; and
  - Clear and understandable software documentation, including information about where to receive additional help.

NOTE: The free-billing software distributed by FIs is maintained by the shared system maintainer. FIs are responsible for testing and distribution of that software only. There is not a similar common source of free billing software or maintenance for the carriers, but carriers are encouraged to contact HGSA, the Pennsylvania carrier, to obtain a copy of the proprietary software developed by that carrier with Federal funds. HGSA has agreed to share that software with other carriers in return for payment of a pro-rata share of the costs that HGSA incurs to distribute and maintain that software. Adminastar has developed a DMERC version of the free billing software. DMERCs are encouraged to contact Adminastar if they need free billing software for distribution to their suppliers.

60.6 - Remittance Advice Print Software

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

60.6.1 - Medicare Remit Easy-Print Software for Carrier and DMERC Provider/Supplier Use

(Rev. 885, Issued: 03-10-06; Effective: 03-15-06; Implementation: 06-01-06)

Although required to offer free DOS-based ERA print software in the National Standard Format (NSF) prior to implementation of the HIPAA claim formats, due to limited use and the greater availability of paper remittance advice notices for professional providers/suppliers, CMS did not require carriers or DMERCs to obtain Windows-based, 835 version 40101A1 compatible ERA print software. Subsequent to that decision, CMS became aware that ERA print software that could be used by providers/suppliers to print out 835 information in the standard paper remittance (SPR) advice format would be cost effective for CMS as well as providers.

CMS has developed software that gives providers/suppliers a tool to read and print an ERA in a readable format. This software is called Medicare Remit Easy Print (MREP). It has been developed in response to comments CMS received from the provider/supplier community that they need a paper document for accounts reconciliation, and claim submission for secondary/tertiary payments. Providers/suppliers who use the MREP software package, have the ability to print paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that can be included with claim submission to secondary/tertiary payers. The output of MREP is similar to the current Standard Paper Remittance (SPR) format. This software became available on October 11, 2005, through respective Part B contractors and DMERCs.

Carriers and DMERCs must eliminate issuance of standard paper remittance advice notices (SPRs) to those providers/suppliers (or a billing agent, clearing house, or other entity representing those providers) also receiving ERA transactions for 45 days or more. Providers and suppliers must be encouraged to use MREP or other software to read, view, and print an electronic remittance advice to eliminate any need for SPRs.

60.6.2 - Medicare Standard FI PC-Print Software

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Institutional providers made greater use of PC-Print than professional providers due to the requirement that institutional paper remittance advice notices be terminated within 30 days after a provider successfully completes testing for acceptance of an electronic remittance advice. FIs are required to issue Windows-based software that a provider may use to convert an X12 835 into a print document. See chapter 22 for further information on the content of the print version of institutional paper remittance advice notices.

The FIs must periodically notify providers that free PC-Print software is available. A FI must make the PC-Print software available on their Web site for downloading by providers. If a provider has difficulty downloading software, or it cannot be posted on a Web site due to copyright restrictions, the provider may be sent a single copy of the PC-Print software; this must be issued within three weeks of the provider's request.

The FI Shared System (FISS) maintainer distributes PC-Print software and a user's guide to FIs through their data center. The software and instructions are designed to be self-explanatory to providers; it should not be necessary to furnish providers training for use of PC-Print software. Providers are responsible for any telecommunication costs associated with receipt of the X12 835 and the cost to print paper remittance advice notices from the X12 835 transactions they are sent. The FISS PC-Print software does not contain copyright restrictions and can be posted on any FIs Web page for provider download.

The PC-Print software enables providers to:

- Receive an 835 electronic remittance advice transmission on a personal computer (PC) over a wire connection and write the 835 file in American National Standard

Code for Information Interchange (ASCII) to the provider's A (floppy disk) or other drive;

- Print 835 data in an easily readable format;
- View and print provider payment summary information;
- View and print a single claim; and
- View and print a sub-total by bill type.

The receiving PC always writes an 835 file in ASCII. The providers may choose one or more print options, i.e., the entire transmission, a single claim, a summary by bill type, and/or a provider payment summary. All file and print formats follow the Medicare national standards described in the SPR specifications (see chapter 22). Since the software performs limited functions, malfunctions should rarely occur. If software malfunctions are detected, FIs are to report them to the FISS maintainer for correction as needed. FIs and data centers are not permitted to modify the PC-Print software. Nor will individual FIs be funded to develop or procure alternate PC-Print software.

60.7 - Newsletters/Bulletin Board/Internet Publication of EDI Information

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

To educate providers and encourage the use of EDI, carriers, DMERCs, and FIs must periodically include information about use of EDI in their newsletters and on their Wb site. Their newsletter and Web site shall:

- Announce upcoming EDI changes;
- Point out common EDI billing errors and provide guidelines to eliminate errors; and
- Promote use of each of the Medicare-supported HIPAA EDI transactions.

Carriers, DMERCs, and FIs will provide access to newsletters via bulletin boards and/or the Internet. Carriers, DMERCs, and FIs Web pages must include a link to the CMS' Web site, which provides record formats and transactions information. If the information is available on the CMS Home page, carriers, DMERCs, and FIs should link to it rather than duplicating development and maintenance. See §40.6 for further instructions on Internet use.

60.8 - Provider Guidelines for Choosing a Vendor

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Providers may request assistance in choosing a vendor. Carriers, DMERCs, and FIs must maintain a list of software vendors and clearinghouses that are currently successfully submitting transactions in HIPAA-compliant formats on their Web page (see §20.6), and are encouraged to also provide factual information such as claims volumes, types of providers serviced by those vendors and clearinghouses, and whether the software may permit automatic posting or printing of 835 data. However, carriers, DMERCs, and FIs must take care to avoid making a specific recommendation and to avoid showing favoritism. Providers may select any vendor that provides the necessary services.

Medicare contractors should post the information in §§60.8.1 through 60.8.4 on their Web page. If a provider asks a Medicare contractor what to consider when searching for a software vendor or clearinghouse, the Medicare contractors should refer the provider to that location on the Web page. Alternately, the information may be sent the provider via e-mail.

60.8.1 - Determining Goals/Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Before selecting a vendor, the provider must examine its business needs to identify the EDI, practice management, or other services that the provider is interested in obtaining from a vendor. The provider should consider what services could be easily performed by their in-house staff and which might be more cost effective to obtain through a vendor. The provider should create a written description of the components of its practice that need vendor support and a description of support needed so prospective vendors can design their proposals to best meet the provider's needs. Requirements to consider include the following:

- Future Growth of the Practice;
- Workload;
- Payer Analysis;
- Referral Tracking;
- Fee Schedules;
- Appointment Scheduling;
- Medical Records;
- Interconnections with Physicians/Hospitals and other Networks;
- Word Processing Needs;
- Electronic Billing (formats and versions supported);

- Multiple Practices/Locations;
- High Volume/Low Volume Billing;
- Specific Bill Types;
- Management Reporting;
- Hardware/Software Requirements/compatibility with existing equipment; and
- Data Storage needs.

60.8.2 - Vendor Selection

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Once a provider has determined its own goals and requirements, it must begin the vendor selection process. Selecting a vendor must be as objective and quantitative as possible. Areas to be evaluated should include technical functionality, flexibility, and customer service. The following steps may be used as guidelines for providers to start the vendor selection process:

1. Develop a list of potential vendors:

- Talk to the Medicare carrier, DMERC, or FI;
- Ask other providers of comparable size/specialties what vendors they use for what services and how satisfied they are;
- Ask a consultant;
- Attend standards conferences, follow trade magazines and investigate Web pages.

2. Call or write the vendors selected/recommended to discuss the organization's needs and request a proposal.

3. Tell the vendors how the proposals should be structured so that the various proposals can be more easily compared.

4. Attend demonstrations of at least two to three vendors and pay close attention to:

- How individual requirements will be met;
- Ease of understanding;
- Ease of features - data entry, search features, editing/compliance checking features, help features, error correction features;

- Security - disaster recovery plans, controls, and audits;
- Daily Procedures;
- Reporting/Tracking features.

5. Check vendor references and ask specific questions such as:

    - How long has the business been in operation?
    - How long has the system been in place?
    - What is the quality of the training and ongoing support?
    - Is there a user's group in place?
    - What formats are supported?

6. Check with providers served by the vendor and ask specific questions such as:

    - Have you experienced any problems with the system?
    - Have you experienced any problems with the vendor?
    - How long did it take to get up and running?
    - Are you happy with the system/vendor and would you recommend it/them today?
    - Is there anything else I should know or ask before making my decision?

Make site visits to the vendor as well as other clients of similar size and bill mix that have been running the system for some time.

60.8.3 - Evaluating Proposals

(Rev. 1, 10-01-03)

Vendor proposals should be evaluated on several levels including company reputation/history, system functionality, flexibility, overall costs, and support provided. Providers should create a checklist that compares the vendor proposals against their original requirements by assigning a relative weight to each requirement and then rating the vendor's ability to meet each requirement based on their written proposals. Although some aspects of each checklist will be highly individual, the following are some of the elements that should be considered:

1. Overall costs:

    - Software costs;

- Hardware costs (types as well as quality);
- Licensing fees;
- Training costs;
- Installation costs;
- Cabling;
- Phone lines (leased line/toll charges);
- Remodeling/Furniture;
- Forms;
- Conversion costs;
- Electricity costs;
- Supply costs (diskettes, tapes, paper, ribbons);
- Annual hardware maintenance;
- Annual software maintenance;
- Cost of custom program changes; and
- Cost of continuous software support.

2. Evaluate hardware differences;

3. Evaluate quality of training and support;

4. Evaluate system documentation;

5. Consider the staff size of the vendor;

6. Determine how well each vendor responded to requirements and questions in the proposals;

7. Determine flexibility (whether the package is proprietary, whether the software can be easily modified, whether the vendor can accommodate changing payer requirements, and if so, at what cost);

8. Determine overall system convenience including hours of customer service, technical support, and connection times;

9. Assess future risks and the vendor mitigation of such risks through system trial periods and source codes placed in escrow.

60.8.4 - Negotiating With Vendors

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Once a vendor has been selected, the provider must negotiate the final costs, services, and implementation dates to be provided by the vendor. All agreements reached between the two parties should be obtained in writing. Providers should add a clause to their agreements that will permit them to obtain a refund in the event the vendor's software does not begin to operate successfully by a specific target date following installation. Providers should also add a clause to their agreements allowing them to delay final payment pending successful operation of the new software for a specified period after successful installation.

70 - EDI Edit Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

70.1 - Carrier, DMERC, and FI X12 Edit Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

A. X12 997 Functional Acknowledgment

Syntax errors prevent processing of the data that follow the error within the same functional group or the same transaction set header in a batch. For purposes of these editing requirements, a transmission of only a single transaction, such as one claim, is considered a batch of one. Syntax errors appear high in the data hierarchy in a batch and apply to all lower level data included in either the same functional group (GS-GE, see the AK1and AK9 segments of the X12 997) or transaction set (ST-SE, see the AK2 and AK5 segments of the X12 997). Although not a HIPAA requirement, CMS requires carriers, DMERCs, and FIs to issue an X12 997 to submitters of X12 transactions when syntax errors are detected to facilitate correction of the errors and resubmission by the submitter of the original batch. CMS also requires contractors to issue an X12 997 to acknowledge receipt of a claim for which there are no errors.

The X12 997 requirements are contained in appendix B at the rear of each version 4010A1 IG adopted as a national standard under HIPAA. Appendix A of those guides contains information on the interchange and application control structures used in the design of X12 standards, explains the basic structure of each X12 transmission, and further defines differences between syntax and semantic edits. Translators must reject all transactions contained in the same functional group of a batch when there is a functional group syntax error, and all transactions within the same transaction group header when there is a syntax error at that level.

B. Translation and Date of Receipt Editing

If a shared system detects an improper flat file format/size (incorrect record length, record length exceeding 32,700 bytes, etc.), the flat file will be rejected back to the file's submitter (carrier, DMERC, FI) by the shared system with an appropriate error message.

The date of receipt of a claim is the date a claim is received by the carrier, DMERC, or FI and not a subsequent date on which the claim may have been received by the shared system. The date of receipt must be an actual calendar date and may not be all zeroes or a future date. See § 80.2.1 of Chapter 1 of this manual for additional information on establishing the date of receipt of a claim.

C. Implementation Guide Edits

In conjunction with front-end translation, FIs are to also conduct IG edits to identify submitted data elements that do not comply with data element requirements added by the IG developers, using either software available from FISS or other software which is able to edit at this level. Carrier and DMERC shared systems conduct IG edits for transactions sent to the carriers and DMERCs. In many cases, IG edits are more restrictive than those established by the X12 standard that served as the platform for development of the IG. For instance, the X12 standard might allow a maximum of 30-digits in a data element, but an IG note could limit the maximum size to 20-digits. Or the number of valid digits that may be entered in a data element as identified by the qualifiers that apply to the data element, might not permit reporting of more than 15-digits even though the standard permits up to 30-digits.

No national standards have been adopted under HIPAA for acknowledgement or error reporting for any of the HIPAA format transactions. At this time, FIs, carriers, DMERCs, and shared system maintainers are allowed to continue to use the proprietary format used pre-HIPAA, or another proprietary format with proprietary messages, to notify submitters of EDI transactions when one or more IG requirements were not met. IG and Medicare program error reports related to electronic transactions must be sent to the submitters of those transactions electronically. IG level edits typically affect a small number of the transactions in a batch. Whenever not precluded by the standard, FIs, carriers, and DMERCs are expected to reject individual transactions that are identified via IG edits and not reject the entire batch of transactions in which those transactions were submitted.

FIs share IG editing responsibilities with FISS (shared system documentation indicates which IG edits are conducted by the shared system). Carrier and DMERC shared systems are responsible for IG editing of professional transactions. When editing for IG compliance, the responsible party must verify that:

- Amounts, percentages, integers, and other fields designated in the IG as numeric are right-justified and zero-filled if the incoming data are smaller than the Medicare flat file field size;

- Fields designated in the IG as alphanumeric are left justified and space filled if the incoming data are smaller than the Medicare flat file field size;

- All non-Medicare data field lengths correspond to the maximum IG length.
- Incoming alphanumeric non-Medicare data are left justified and space filled if the data are smaller than the Medicare flat file field size;
- Incoming numeric non-Medicare data are right justified and zero-filled if the data contain fewer integers than the Medicare flat file field size;
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are mapped to the Medicare flat file (and later written to the store-and-forward repository (SFR) by the shared system); and
- All decimal data elements are defined as "R" and translators write these data elements to the X12-based flat file at their maximum field size (which is initialized to spaces). The COBOL picture found under the X12 element name must be used to limit the size of the amounts. These positions must be right justified and zero-filled. Contractor translators must convert signed values using the conversion table shown below. This value must be placed in the last position of the COBOL-defined field length. The last position of maximum defined field length of the X12-based flat file data element is used as a placeholder by Medicare to report an error code if an "R" defined data element exceeds the limitation that the Medicare system is authorized to process. The error code values are:
    - "X" = value exceeds maximum amount based on the COBOL picture,
    - "Y" = value exceeds maximum decimal places based on the COBOL picture,
    - "Z" = value exceeds x-number of precision places, and
    - "b" blank represents no error.

For example, a dollar amount with the IG maximum of 18-digits would look like 12345678.90. The contractor translator maps this amount to the X12N-based flat file using the COBOL picture of S9(7)V99. The flat file amount looks like 23456789{bbbbbbbbX. The "{" is the converted sign value for positive "0." The error switch value is "X" since this value exceeded the COBOL picture of S9(7)V99.

Conversion Table

Positive Values	**Negative Values**
1 = A	-1 = J
2 = B	-2 = K
3 = C	-3 = L

Positive Values	Negative Values
4 = D	-4 = M
5 = E	-5 = N
6 = F	-6 = O
7 = G	-7 = P
8 = H	-8 = Q
9 = I	-9 = R
0 = {	-0 = }

70.2 - Supplemental FI-Specific Shared System Edit Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

A. FI Edits

1. Left justify a ZIP Code that exceeds nine positions.

2. FIs must return to the submitter individual transactions identified by their edits that contain data that meets the syntax requirement of the standard on which a HIPAA adopted IG is based, but exceed tighter requirements in the IG as signified by an IG note, internal code list, external code list, or qualifier. An appropriate error message must accompany the returned transactions. Likewise, the shared system is responsible for return of individual transactions in this situation when identified by IG edits applied by FISS, and the issuance of appropriate error messages to describe the reason the transactions are being returned.

3. Reject individual transactions with an appropriate error message if the Employer Identification Number (EIN) exceeds 10 positions.

4. Disregard submitted data if in a data element labeled “NOT USED” in the IG adopted as a HIPAA standard.

5. Enter all spaces in any Medicare flat file fields that the HIPAA IG does not require and which are not submitted in a transaction.

6. Reject dates with an appropriate error message that exceed eight digits (CCYYMMDD), unless used to report date ranges.

7. Flag claims for rejection by the shared system if the attending, referring, or operating physician numbers exceed 16 positions.

8. Flag claims for rejection by the shared system if the units of service exceed seven positions.

9. Flag claims for rejection by the shared system if the number of days (covered, lifetime reserve, etc.) exceeds four positions.

10. Disregard credit card and foreign currency data per note in the HIPAA IG stating that this information must never be sent to the payer. Do not include such disregarded data in any COB transaction.

11. Map translator to convert submitted amounts to the Medicare flat file using the COBOL picture of S9(8)V99 (10 positions). Map other numeric data elements to the data size described within the Medicare flat file documents. Populate numeric data fields larger than the data size described within the Medicare flat file documents with all nines.

12. Write the first 449 lines of an institutional claim submitted with more than 449 lines to the Medicare Part A Claim/COB flat file. The shared system will return the claim to the submitter with an appropriate error message based on the missing 0001 entry in line 450.

13. Round units of service that contain decimals when translating from the X12 claim to the Medicare flat file (i.e., if the number to the right of the decimal is four or less, round down. If the number to the right of the decimal is five or greater, round up). Although the HIPAA IG permits decimals, Medicare does not process units of service that contain any decimals or diagnosis codes containing decimals.

14. If an incoming institutional claim contains a diagnosis code with a decimal in the correct position based on the external code source, the FI must reformat the diagnosis code into a 6-position alphanumeric field as defined in the Medicare Part A/COB flat file (flat file) where the digits are left justified and space filled when translating the data into the flat file format. The decimal will be assumed between the third and fourth digit (i.e., 999V9bb - “V” represents the assumed decimal and “b” represents a space). If an incoming claim contains a diagnosis code with a decimal in an incorrect position based on the external code source populate (flag) the field with ampersands.

15. Suppress the one HCPCS code per (Revenue Code edit in FI translators to prevent rejection of outpatient claims with line level (Revenue codes but no HCPCS code.

16. Suppress the FI translator edit for the absence of a date of service where there are no HCPCS codes.

17. Return claims containing a diagnosis code flagged with ampersands to the provider/submitter, via the FI, with an appropriate error message.

18. Return claims with numeric data elements containing all nines to the submitter via the FI with an appropriate error message.

19. Return claims with S9(8)V99 numeric data elements containing an amount greater than corresponding fields set in the core system at 9 digits (S9(7)V99) to the submitter via the FI with an appropriate error message.

20. Return data residing on the Medicare Part A Claim/COB flat file as a result of data received in loop 2010BD RESPONSIBLE PARTY NAME of the HIPAA claim IG via the FI with an appropriate error message because Medicare policy requires a signature on file for payment.

21. Do not return data not required or not used by Medicare, except as directed when COB applies.

FISS DDE Edit Requirements

1. Edit bill types 12X and 22X to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present when submitted via DDE (these are already required for other inpatient bill types). Claims not containing this data shall be identified as an error with an appropriate error message.

2. Effective January 1, 2005, edit outpatient claims submitted via DDE to ensure each contains a line item date of service (LIDOS) for each (Revenue code. Any outpatient claims found without a LIDOS for each (Revenue code shall be identified as an error with an appropriate on-line error message.)

3. Effective January 1, 2005, edit outpatient claims submitted via DDE to detect Covered Days. Any outpatient claims submitted via DDE containing Covered Days shall be identified as an error with an appropriate error message.

4. Effective January 1, 2005, edit all claims submitted via DDE to ensure each does not contain a NPP000 UPIN. Any claims submitted via DDE containing a NPP000 UPIN shall be identified as an error with an appropriate error message.

5. Effective October 1, 2004, edit all claims submitted via DDE to detect invalid E-codes (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims found containing an invalid E-code shall be identified as an error with an appropriate error message.

6. Effective October 1, 2004, edit all claims submitted via DDE to detect submission of an invalid diagnosis code (a diagnosis code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid condition code (a condition code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid value code (a value code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid occurrence code (an occurrence code not listed in the external code source referenced by the HIPAA 837 institutional IG), or an invalid occurrence span code (an occurrence span code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims submitted via DDE containing an invalid condition code, value code,

diagnosis code, occurrence code, or occurrence span code shall be identified as an error with an appropriate error message.

7. Edit outpatient claims received via DDE to detect submission of an ICD-9 procedure code. Any outpatient claim found containing an ICD-9 procedure code shall be identified as an error with an appropriate error message. (Note: CR 3264 clarified that this edit applies only to outpatient claims.)

8. The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims received via DDE to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be identified as an error with an appropriate error message.

70.2.1 - FI HIPAA Claim Level Implementation Guide Edits

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

A. FISS IG Edit Module

The FIs must reject 837 claims that contain implementation guide (IG) or Medicare program-only errors at the claim level. FIs that are unable to reject individual claims in a batch that have IG or Medicare program errors when the batch is syntactically correct, and there are no errors higher in the batch hierarchy that would prevent processing, must install the FISS IG edit module. This edit module is able to reject claims that have implementation guide (IG) errors at the claim level (see example below). If a batch of claims passes the basic syntax edits, the FISS IG edit module will be invoked and only claims that fail the IG edits will be rejected and appropriate error messages issued.

ISA (example 1)

GS (example 2)

ST (example 3)

PROV A

SUBSCRIBER A (example 5)

CLAIM A1 (example 6)

CLAIM A2

CLAIM A3

SUBSCRIBER AA

CLAIM AA1

CLAIM AA2

PROV B (example 4)

SUBSCRIBER B

CLAIM B1

CLAIM B2 (example 6)

CLAIM B3

SE

ST

PROV C

SUBSCRIBER C

CLAIM C1

CLAIM C2

CLAIM C3 (example 6)

PROV D

SUBSCRIBER D

CLAIM D1

CLAIM D2

CLAIM D3

SE

GE

IEA

Example 1 (ISA-IEA level edit): Any errors found at this level (envelope) will result in all claims within the ISA-IEA being rejected via a TA1. (See Appendix B, p.11 in an X12 HIPAA IG for TA1 segment requirements.)

Example 2 (GS-GE level edit): Any errors found at this level will result in all claims within the GS-GE being rejected via an X12 997. In this example all claims would be rejected. If a second GS-GE loop followed the first and passed all edits, then any claims within the second GS-GE would be entered into the system providing they passed the IG edits.

Example 3 (ST-SE level edit): Any errors found at this level will result in all claims within the ST-SE being rejected and reported in a proprietary format transmission message. In this example assume only the first ST had errors. In this case claims A1, A2, A3, B1, B2, and B3 would be rejected. Claims C1, C2, C3, D1, D2, and D3 would be entered into the system providing they passed lower level IG edits.

Example 4 (Provider level IG edit): Any errors found at this level will result in all claims for this provider being rejected. In this example assume only the Provider B had errors (such as an invalid provider number). In this case, claims A1, A2, A3, C1, C2, C3, D1, D2, and D3 would be entered into the system providing they passed lower level IG edits and claims B1, B2, and B3 would be rejected.

Example 5 (Subscriber level IG edit): Any errors found at this level will result in all claims for this subscriber being rejected. In this example, claims for Subscriber A (A1, A2, and A3) would be rejected. Claims for Subscriber AA (AA1 and AA2) would be entered into the system providing they passed lower level IG edits.

Example 6 (Claim level IG edit): Any errors found at this level will result in only that claim(s) being rejected. In this example assume only claims A1, B2 and C3 had errors. All of the other claims would be entered into the system providing they passed lower level IG edits.

B. Additional FI IG Edits

1. Neither the FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, nor an FI if editing separately shall reject any outpatient claims reported with the "ZZ" qualifier that contain a Health Insurance Prospective Payment System (HIPPS) Rate Codes. (Note: CR 3264 effective October 1, 2004 clarified that this edit applies to outpatient claims only.)

2. Each FI must operate an edit module developed by the shared system maintainer to edit 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X outpatient (as defined in Pub. 100-04 Transmittal 107, CR 3031) type claims to ensure each contains a line item date of service (LIDOS) for each (Revenue code. Claims not containing a LIDOS for each (Revenue code shall be rejected back to the submitter with an appropriate error message, and not forwarded to the shared system.

3. The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit all outpatient claims to identify any that contain a Covered Days (QTY) segment. Outpatient claims containing Covered Days shall be rejected with an appropriate error message, and not forwarded to the shared system.

4. The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall reject all claims containing a

NPP000 UPIN with an appropriate error message, and not forward those claims to the shared system.

5. For outbound X12N 837 HIPAA COB transactions, the FI shall edit all claims to ensure that any containing service line adjudication information also contain an appropriate service line adjudication date (the paid claim date).

6. The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall reject all occurrences in inbound claims of invalid: E-codes, condition codes, value codes, occurrence codes, and occurrence span codes with an appropriate error message, and not forward those claims to the shared system.

7. The healthcare provider taxonomy codes (HPTCs) must be loaded by the FIs into a contractor-controlled table designed by the shared system maintainer. HPTCs may not be hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future updates. HPTCs are updated twice a year (tentatively October and April). That list may be downloaded in portable document format (PDF) from the Washington Publishing Company (WPC) for no charge at wwww.wpc-edi.com/codes, or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. FIs are to use the most cost effective means to obtain the list for validation programming and updating purposes.

8. The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit all claims to ensure that submitted HPTCs comply with both the data attributes for the data element as contained in the HIPAA 837 IG, and are valid. To be valid, a HPTC must appear in the latest HPTCs update FIs were required to implement by CMS. HPTCs are not reported in a required data element, but claims received with invalid HPTCs shall be rejected with an appropriate error message, and not forwarded to the shared system.

9. The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit all outpatient claims to ensure each containing (Revenue code 045X, 0516, or 0526 also contain an HI02-1 code of "ZZ", along with a compliant "Patient Reason for Visit" diagnosis code. Outpatient claims containing an invalid "Patient Reason for Visit" diagnosis code that is not listed in the external code source referenced by the HIPAA 837 institutional IG shall be rejected from the flat file with an appropriate error message, and not forwarded to the shared system. (Note: CR 3264 effective October 1, 2004 clarified that this applies to outpatient claims only.)

10. FISS shall ensure that a "ZZ" qualifier is populated in the flat file field for HI02-1 when (Revenue code 045X, 0516, or 0526 is present in an outpatient claim and an outbound X12N 837 COB transaction is being prepared. (Note: CR 3264 effective October1, 2004 clarified that this applies to outpatient claims only.)

11. For bill types 12X and 22X, the FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit to ensure admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present on an inbound 837 (contractors should already be editing other inpatient bill types to ensure these are required). Claims not containing this data shall be rejected with an appropriate error message and not forwarded to the shared system.

70.3 - Supplemental Carrier/DMERC-Specific Shared System Implementation Guide Edit Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

1. Carriers and DMERCs must reject inbound electronic claims that contain invalid diagnosis codes whether or not pointed to a specific detail line.

2. Carriers and DMERCs must reject inbound electronic claims that contain a space, dash, special character, or less than 5 byte numeric in any zip code.

3. Carriers and DMERCs must reject inbound electronic claims that contain a space, dash, special character, or parentheses in any telephone number.

4. The Carrier and DMERC shared systems shall apply IG edits to paper claims only for those requirements that are applicable to both the HIPAA format for electronic claims as well as to paper claims. IG edits must otherwise be bypassed for claims submitted on paper.

70.4 - Key Shop and Image Processing

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

CMS ceased support of the NSF and UB-92 flat file claims effective October 1, 2005 with termination of the HIPAA incoming claim contingency plan. Medicare contractors were required to migrate to either the X12-based flat file or the HIPAA 837 as the output format for external key shop, claims keyed by their own staff members, and OCR/ICR imaged claims sent their data center effective October 1, 2004.

Key shop, imaging, and contractor in-house data entry operations that do not output directly in the HIPAA 837 or X12-based flat file format, must convert their initial output format into the X12-based flat file or the HIPAA 837 format prior to transmission to their data center. When the X12-based flat file is the output, the REF01 segment/element (found prior to the ST segment) shall contain a value of “+PR” and REF02 shall contain a value of “K” (external key shop or in-house data entry) or “O” (OCR/ICR).

Shared systems shall apply IG edits only to those requirements that are applicable to both the HIPAA and the corresponding fields on the paper claim. Implementation guide edits that are inappropriate for paper claims shall be by-passed.

An outbound 837 COB transaction built from a paper claim will be produced as a "skinny" COB. Gap filling must occur as needed to enable the file sent to the trading partner to meet minimum data set requirements for a compliant 837 version 4010A1 COB transaction. "Skinny" COBs shall contain all required 837 segments and include post-adjudicated data.

80 - Security

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

80.1 - Carrier, DMERC, or FI Data Security and Confidentiality Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

All Medicare beneficiary-specific information is confidential and subject to the requirements of §1106(a) of the Act and implementing regulations at 42 CFR Part 401, Subpart B. Those regulations specify that, as a general rule, every proposed disclosure of Medicare information shall be subject to the Freedom of Information Act rules at 45 CFR Part 5. Also all such information, to the extent that it is maintained in a "system of records," is protected under the provisions of the Privacy Act of 1974 (5 USC. 552a) and implementing regulations at 45 CFR Part 5b. Such information is included in claims, remittance advice, eligibility information, online claims corrections, and any other transactions where personal information applicable to a beneficiary is processed or transported. Such information may not be disclosed to anyone other than the provider or supplier that submitted a claim or to the beneficiary for whom a claim was filed. Carriers, DMERCs, and FIs must ensure the security of all EDI transactions and data. See the CMS Business Partners System Security Manual and its Core Security Requirements attachment for more detailed information on system security requirements.

Carrier, DMERC, and FI systems must include the following system security capabilities:

- All data must be password protected and passwords modified at periodic but irregular intervals, as well as when an individual having knowledge of the password changes positions, and when a security breach is suspected or identified;

- Provide mechanisms to detect unauthorized users and prohibit access to anyone who does not have an appropriate user ID and password;

- Maintain a record of operator-attempted system access violations;

- Maintain a multi-level system/user authorization to limit access to system functions, files, databases, tables, and parameters from external and internal sources;

- Maintain updates of user controlled files, databases, tables, parameters, and retain a history of update activity; and

- Protect data ownership and integrity from the detailed transaction level to the summary file level.

80.2 - Carrier, DMERC, and FI EDI Audit Trails

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs must maintain an automated transaction tracking and retrieval capability and retain an audit trail that notes each change made to each claim from date of receipt to date of payment or denial and any subsequent adjustments. Carriers, DMERCs, and FIs must be able to retrieve or recreate:

- The claim as received (pre-translation) from the provider, billing service, or clearinghouse;

- The claim as paid to the provider;

- All adjustments made on the claim;

- The check or the electronic funds transfer (EFT) record sent to the provider; and

- The remittance advice as sent to the provider.

Carriers, DMERCs, and FIs must maintain the ability to cross-refer all associated transactions, e.g., EFT or check, claim adjustment, remittance advice, to each related claim being processed. The records may be kept on electronic, computer-output-microfilm, optical disk media, or other reliable and industry accepted types of storage and retrieval media. They may never allow anyone to overlay or erase a record. Each record must be kept intact. All records must be archived in accordance with the instructions in the Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-01, Chapter 7. It is important to have a well-defined system for maintaining audit trail data so that data integrity is maintained at all times.

80.3 - Security-Related Requirements for Carrier, DMERC, or FI Arrangements With Clearinghouses and Billing Services

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

A billing service is an entity that markets claim preparation services to providers and may also be able to perform related transactions for providers, such as eligibility and claim status inquiries. The billing service collects a provider's claim information and then bills the appropriate insurance companies, including Medicare. A billing service may submit claims only, or provide full financial accounting and/or other services. Billing services are considered to be provider business associates. As such, HIPAA requires that they comply with each of the privacy and security requirements that apply directly to

providers. They are also required to ensure that they require that any clearinghouses, subcontractors or other business associates of their own that may be involved with handling of Medicare beneficiary data also meet those same security and privacy requirements. A billing service may view beneficiary or provider data to carry out their billing obligations for a provider, when a provider authorizes them to have that access. To qualify as a billing service, an entity must at a minimum submit initial claims on the provider's behalf.

A clearinghouse transfers or moves EDI transactions for a provider or billing service, and generally translates the EDI transactions from or into a proprietary format. (HIPAA defines a clearinghouse as a business associate of a provider or a health care plan that translates data from a non-standard format into a standard format or vice versa as preferred by their clients.) A clearinghouse generally accepts multiple types of incoming transactions and sends them to various payers, including Medicare. Clearinghouses often perform general and payer-specific edits on claims, and may handle multiple types of EDI transactions for a given provider. Clearinghouses frequently reformat data for various payers, and manage acknowledgements, remittance advice transactions, and claim status and eligibility queries.

Some entities that refer to themselves as clearinghouses, however, do not edit or translate data, but simply serve as a "telecommunication switch," moving transactions from point A to Point B or wherever directed under the terms of the agreement with a provider. A clearinghouse may also be called a value added network (VAN), or when eligibility data are involved, are sometimes called Network Service Vendors (NSVs). A clearinghouse/VAN/NSV may not view privacy-protected Medicare data unless a signed authorization has been filed by the provider for whom the clearinghouse/VAN/NSV will submit or received Medicare EDI transactions. For EDI, a transaction that contains individually identifiable information about a Medicare beneficiary is considered to be privacy protected data.

That provider may not authorize submission or receipt of data by a third party for a Medicare beneficiary unless that beneficiary is a current patient of the provider, has scheduled an appointment, or has inquired about the receipt of supplies or services from the provider. The provider authorization must be filed with the Medicare contractor to whom EDI transactions will be sent or from whom they will be received. In the case of a DMERC, this authorization need only be submitted to one of the four DMERCs. If multiple carriers or FIs may be involved, an authorization must be submitted to each.

Each clearinghouse/VAN/NSV that will submit or receive Medicare EDI transactions is prohibited from using the EDI number or password issued to any of the providers they serve. Each clearinghouse/VAN/NSV must obtain its own EDI number and password from each carrier, DMERC, or FI with which it will interact.

Some health care providers use or may want to use more than one billing service or clearinghouse/VAN/NSV. Medicare contractor ability to handle more than one agent varies. Some contractors are able to accommodate one or more clearinghouses/VAN/NSV for submission of a provider's claims to Medicare, another

agent to receive the provider's remittance advice transactions, and a third clearinghouse/VAN/NSV to verify beneficiary Medicare eligibility for a provider. Others may not be able to accommodate more than one agent for a provider. DMERCs, carriers and FIs are encouraged to support more than one agent for a provider, when permitted by their front end configuration.

Medicare contractors must notify each provider that applies for permission to obtain eligibility data electronically that:

- They are permitted to view Medicare eligibility data only for patients currently being treated by or who have requested treatment or supplies from that provider;

- A provider cannot authorize a billing agent or clearinghouse to submit or obtain data from a Medicare contractor that the provider is not entitled to personally submit or obtain;

- A request for personally identifiable information for any other Medicare beneficiaries would be a violation of Medicare and HIPAA privacy requirements, and subject to the applicable penalties for such violations.

Medicare contractors must notify each billing service and clearinghouse/VAN/NSV at the time of their application for access to Medicare eligibility data and by also posting information on their web site that:

- Their access is limited to submission of transactions and receipt of transactions for those providers that are their clients, but only if those providers authorized the billing agent and/or clearinghouse/VAN/NSV to submit or receive each transaction.

- A billing agent or clearinghouse/VAN/NSV that has provider authorization to submit claim data for a provider cannot obtain eligibility data for that provider unless that was specifically authorized by the provider.

- Likewise, the billing agent or clearinghouse/VAN/NSV cannot be sent remittance advice transactions for a provider unless specifically authorized to do so by that provider.

Providers must submit these authorizations to their Medicare contractor in writing; a Medicare contractor is not permitted to accept a statement signed by a billing agent or clearinghouse/VAN/NSV alleging that they have such provider authorization on file. An original provider signature is required on these authorizations (but a contractor is allowed to accept an authorization signed by a provider by fax or mail). The carrier, DMERC, or FI is responsible for maintenance of files to establish system access for individual providers, identify those billing agents and clearinghouses/VAN/NSV authorized to access systems as the agent of a specific provider, and to record those transactions for which a billing agent or clearinghouse/VAN/NSV is authorized access as the representative of a specific provider.

With authorization, a clearinghouse/VAN/NSV may send inquiries for a provider, and receive responses, but it may not view personally identifiable beneficiary data contained in those queries or responses, store it for longer than necessary to assure delivery to the provider (no longer than 30 days maximum), or use personally identifiable data in any reports. The EDI data sent or received belongs ultimately to the beneficiary, not to the clearinghouse/VAN/NSV that may translate and transport the data for a provider acting on the beneficiary's behalf.

Collection agents that contract with providers to collect "bad debts" and third party entities that may analyze data but do not have a specific initial claim submission role or are not responsible for posting of information in a remittance advice to patient accounts may not be sent beneficiary data by a Medicare contractor. If a collection agent or such a third party has provided adequate privacy and security assurances to protect beneficiary data, the provider may share Medicare payment information with a collection agent, data analysis firm, or similar third party, but the provider would need to furnish that data to that entity agent in this situation, however. The Medicare program may not incur costs to furnish such data to collection agencies or to other entities that perform services that do not directly support Medicare activities. Delinquent collection, analysis of data related to a provider's operations, and expenses related to other activities not directly related to Medicare claims or payments are considered provider business expenses. Such activities do not directly benefit Medicare and Medicare may not incur costs to supply data intended only for such uses.

A provider must sign a valid EDI Enrollment Form (see section 20 of this chapter) prior to authorizing a billing agent or clearinghouse/VAN/NSV to submit/receive any EDI transactions on their behalf. A separate password is to be used for system access by each authorized provider, billing agent or clearinghouse. A vendor provides hardware, software and/or ongoing support for total office automation or submission of electronic EDI transactions directly to individual providers, billing agent or clearinghouses/VANs/NSVs. Vendors supply the means for Medicare system access but have no right to direct access to Medicare contractor systems.

Vendor software is normally tested when it first begins to be used by providers, billing agents or clearinghouses/VANs/NSVs. At the request of a vendor or a clearinghouse/VAN/NSV, a Medicare contractor may, but is not required to, test new software before a provider has agreed to begin using that software to exchange Medicare EDI transactions with the contractor. When testing software prior to use by a provider, a Medicare contractor may not furnish a software vendor who does not currently submit or receive Medicare transactions with an EDI access number or password which would permit the vendor to access to actual Medicare beneficiary data. That software is to be tested using a test database or by other means that would not disclose actual beneficiary data to the vendor. This EDI access limitation for testing of new software does not apply to a clearinghouse/VAN/NSV with a history of submission/receipt of EDI transactions with the contractor, or when a software vendor is also a clearinghouse/VAN/NSV or a provider billing agent (in which case, testing should only involve data for beneficiaries for which the entity already submit/receives transactions).

90 – Mandatory Electronic Submission of Medicare Claims

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L. 107-105, and the implementing regulation at 42 CFR 424.32 require that all initial claims for reimbursement under Medicare, except from small providers, be submitted electronically as of October 16, 2003, with limited exceptions. Initial claims are those claims submitted to a Medicare fee-for-service carrier, DMERC, or FI for the first time, including resubmitted previously rejected claims, claims with paper attachments, demand bills, claims where Medicare is secondary, and non-payment claims. Initial claims do not include adjustments or claim corrections submitted to FIs on previously submitted claims or appeal requests.

Medicare is prohibited from payment of claims submitted in a non-electronic manner that do not meet the limited exception criteria. Claims required to be submitted electronically effective October 16, 2003, and later must comply with the appropriate claim standards adopted for national use under HIPAA (see section 40 of this chapter). The mandatory electronic claim submission requirement does not apply to claims submitted by beneficiaries or by providers that only furnish services outside of the United States, claims submitted to Medicare managed care plans, or to health plans other than Medicare.

90.1 – Small Providers and Full-Time Equivalent Employee Self-Assessments

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

A "small provider" is defined at 42 CFR section 424.32(d)(1)(vii) to mean A) a provider of services (as that term is defined in section 1861(u) of the Social Security Act) with fewer than 25 full-time equivalent (FTE) employees; or B) a physician, practitioner, facility or supplier that is not otherwise a provider under section 1861(u) with fewer than 10 FTEs. To simplify implementation, Medicare considers all providers that have fewer than 25 FTEs and that are required to bill a Medicare FI to be small; and considers all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a Medicare carrier or DMERC to be small.

The ASCA law and regulation do not modify pre-existing laws or employer policies defining full time employment. Each employer has an established policy, subject to certain non-Medicare State and Federal regulations, that define the number of hours employees must work on average on a weekly, biweekly, monthly, or other basis to qualify for full-time benefits. Some employers do not grant full-time benefits until an employee works an average of 40 hours a week, whereas another employer might consider an employee who works an average of 32 hours a week to be eligible for full-time benefits. An employee who works an average of 40 hours a week would always be considered full time, but employees who work a lesser number of hours weekly on average could also be considered full time according to the policy of a specific employer.

Everyone on staff for whom a health care provider withholds taxes and files reports with the Internal (Revenue Service (IRS) using an Employer Identification Number (EIN) is considered an employee, including if applicable, a physician(s) who owns a practice and provides hands on services and those support staff who do not furnish health care services but do retain records of, perform billing for, order supplies related to, provide personnel services for, and otherwise perform support services to enable the provider to function. Unpaid volunteers are not employees. Individuals who perform services for a provider under contract, such as individuals employed by a billing agency or medical placement service, for whom a provider does not withhold taxes, are not considered members of a provider's staff for FTE calculation purposes when determining whether a provider can be considered as "small" for electronic billing waiver purposes.

Medical staff sometimes work part time, or may work full time but their time is split among multiple providers. Part time employee hours must also be counted when determining the number of FTEs employed by a provider. For example, if a provider has a policy that anyone who works at least 35 hours per week on average qualifies for full-time benefits, and has 5 full-time employees and 7 part-time employees, each of whom works 25 hours a week, that provider would have 10 FTEs (5+[7 x 25= 175 divided by 35= 5]).

In some cases, the EIN of a parent company may be used to file employee tax reports for multiple providers under multiple provider numbers. In that instance, it is acceptable to consider only those staff, or staff hours worked for a particular provider (as identified by provider number, UPIN, or national provider identifier (NPI) when implemented) to calculate the number of FTEs employed by that provider. For example, ABC Health Care Company owns hospital, home health agency (HHA), ambulatory surgical center (ASC), and durable medical equipment (DME) subsidiaries. Some of those providers bill FIs and some carriers. All have separate provider numbers but the tax records for all employees are reported under the same EIN to the IRS. There is a company policy that staff must work an average of 40 hours a week to qualify for full time benefits.

Some of the same staff split hours between the hospital and the ASC, or between the DME and HHA subsidiaries. To determine total FTEs by provider number, it is acceptable to base the calculation on the number of hours each staff member contributes to the support of each separate provider by provider number. First, each provider would need to determine the number of staff who work on a full-time basis under a single provider number only; do not count more than 40 hours a week for these employees. Then each provider would need to determine the number of part-time hours a week worked on average by all staff who furnished services for the provider on a less than full-time basis. Divide that total by 40 hours to determine their full-time equivalent total. If certain staff members regularly work an average of 60 hours per week, but their time is divided 50 hours to the hospital and 10 hours to the ASC, for FTE calculation purposes, it is acceptable to consider the person as 1 FTE for the hospital and .25 FTE for the ASC.

In some cases, a single provider number and EIN may be assigned, but the entity's primary mission is not as a health care provider. For instance, a grocery store's primary role is the retail sale of groceries and ancillary items including over the counter

medications, but the grocery store has a small pharmacy section that provides prescription drugs and some DME to Medicare beneficiaries. A large drug store has a pharmacy department that supplies prescriptions and DME to Medicare beneficiaries but most of the store's revenue and most of their employees are not involved with prescription drugs or DME and concentrate on non-related departments of the store, such as film development, cosmetics, electronics, cleaning supplies, etc. A county government uses the same EIN for all county employees but their health care provider services are limited to furnishing of emergency medical care and ambulance transport to residents. For FTE calculation purposes, it is acceptable to include only those staff members of the grocery store, drug store, or county involved with or that support the provision of health care in the FTE count when assessing whether a small provider waiver may apply.

Support staff who should be included in the FTE calculation in these instances include but are not necessarily limited to those that restock the pharmacy or ambulance, order supplies, maintain patient records, or provide billing and personnel services for the pharmacy or emergency medical services department if under the same EIN, according to the number of hours on average that each staff member contributes to the department that furnishes the services or supplies for which the Medicare provider number was issued.

Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

In the event that a provider uses a clearinghouse or a billing agent to submit claims, it is the number of FTEs on the provider's staff, not those on the staff of the billing agent or the clearinghouse, that determine whether the provider may be considered small for Medicare paper claim submission purposes.

90.2 – Exceptions

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

In some cases, it has been determined that due to limitations in the claims transaction formats adopted for national use under HIPAA, it would not be reasonable or possible to submit certain claims to Medicare electronically. Providers are to self-assess to determine if they meet these exceptions. At the present time, only the following claim types are considered to meet this condition for self-assessment purposes:

1. Roster billing of inoculations covered by Medicare—Although flu shots and similar covered vaccines and their administration can be billed to Medicare electronically, one claim for one beneficiary at a time, in the past, some suppliers were allowed to submit a single claim on paper with the basic provider and service data and to attached a list of the Medicare beneficiaries to whom the vaccine was administered and related identification information for those beneficiaries. The claim IGs adopted under HIPAA can submit single claims to a

payer for single individuals, but cannot be used to submit a single claim for multiple individuals.

Flu shots are often administered in senior citizen centers, grocery stores, malls, and other locations in the field. It is not always reasonable or hygienic to use a laptop computer to register all necessary data to enable a HIPAA-compliant claim to be submitted electronically in such field situations. In some cases, an unaccompanied nurse might inoculate a large number of beneficiaries. Due to the low cost of these vaccinations, it is not always cost effective to obtain all of the data normally needed for preparation of a HIPAA-compliant claim. Such suppliers rarely have a long-term health care relationship with their patients and do not have a need for the extensive medical and personal history routinely collected in most other health care situations.

It is in the interest of Medicare and public health to make it as simple as possible for mass inoculation activities to continue. Although suppliers are encouraged to submit these claims to Medicare electronically, one claim for one beneficiary at a time, this is not required except in the case of multi-state companies that signed an agreement with a single Medicare contractor for submission of all flu shots to that single contractor for those states, and who agreed to submit those claims electronically as a condition for centralized billing of those inoculations. In the absence of an electronic format that would allow a single claim for the same service to be submitted on behalf of multiple patients using abbreviated data, suppliers currently allowed to submit paper roster bills may continue to submit paper roster bills for inoculations.

This inoculation waiver applies only to injections such as flu shots frequently furnished in non-traditional medical situations, and does not apply to injections including flu shots when furnished in a traditional medical setting such as a doctor's office or an outpatient clinic as a component of other medical care or an examination. In traditional medical situations where the provider is required to bill the other services furnished to the patient electronically, a flu shot or other inoculation is also to be included in the electronic claim sent to Medicare for the patient.

2. Claims for payment under a Medicare demonstration project that specifies paper submission—By their nature, demonstration projects test something not previously done, such as coverage of a new service. As a result of the novelty, the code set that applies to the new service may not have been included as an accepted code set in the claim implementation guide(s) adopted as HIPAA standards. The HIPAA regulation itself makes provisions for demonstrations to occur that could involve use of alternate standards. In the event a Medicare demonstration project begins that requires some type of data not supported by the existing claim formats adopted under HIPAA, Medicare could mandate that the claims for that demonstration be submitted on paper. In the event demonstration data can be supported by an adopted HIPAA format, Medicare will not require use of paper claims for a demonstration project. Demonstrations typically involve

a limited number of providers and limited geographic areas. Providers that submit both demonstration and regular claims to Medicare may be directed to submit demonstration claims on paper. Non-demonstration claims must continue to be submitted electronically, unless another exception or waiver condition applies to the provider.

3. Medicare Secondary Payer Claims—Providers may submit their secondary claims to Medicare non-electronically when a primary payer has made an "Obligated to Accept as payment in Full" (OTAF) adjustment and there is more than one primary payer. Providers have been directed to report OTAF adjustments in a CN1 segment of a claim, but it is not possible to either identify which primary payer owns a reported OTAF adjustment, or to report more than one OTAF adjustment in the event they apply to each primary payer. An OTAF adjustment is made when a provider, physician or supplier accepts or negotiates receipt of a set amount that may be lower than a payer's normal allowed amount as payment in full for particular services or supplies. In any case where an OTAF-type adjustment applies, the physician, supplier or other provider would either have signed an agreement to that effect with the particular payer(s) or would have received notification from the particular payer(s) of this situation and of the services or supplies to which it applies. By regulation, if the OTAF amount is lower that the charge for the related service that appears on the claim, Medicare must include an OTAF adjustment when calculating the amount of Medicare's secondary payment.

   Providers are required to submit their Medicare secondary claims to Medicare electronically however, when they are for services for which no OTAF rate applies or when a claim includes an OTAF adjustment but there is only one payer primary to Medicare.

4. Claims submitted by Medicare beneficiaries.

90.3 – "Unusual Circumstance" Waivers

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Congress granted the Secretary considerable discretion to decide what other circumstances should qualify as "unusual circumstances" for which a partial (applies to certain claim types or for a defined period of time) or full waiver of the electronic claim submission requirement would be appropriate. The Secretary delegated that authority to CMS. In the event it is determined that enforcement of the electronic claim submission requirement would be against equity and good conscience as result of an "unusual circumstance," CMS will waive the electronic claim submission requirement for temporary or extended periods. In those situations, providers are encouraged to file claims electronically where possible, but electronic filing is not required.

CMS has in turn delegated certain authority to the Medicare carriers, DMERCs, and FIs to determine whether an "unusual circumstance" applies. Providers who feel they should qualify for a waiver as result of an "unusual circumstance" must submit their waiver

requests to the Medicare carrier, DMERC or FI to whom they submit their claims. The Medicare contractor must issue a form letter (Exhibit A) in the event of receipt of a written waiver request that does not allege an "unusual circumstance."

As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision must be addressed to the organizational name of a provider and not to an individual (either a sole practitioner, employee or the owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or the name used to obtain an EIN from the IRS.

In some cases, an "unusual circumstance" or the applicability of one of the other exception criteria may be temporary; in which case, the related waiver would also be temporary. Once the criteria no longer apply, that provider is again subject to the Medicare electronic claim submission requirement. Likewise, some exception and waiver criteria apply to only a specific type of claim, such as an OTAF secondary claim when there is more than one primary payer. Other claim types not covered by an exception or waiver must still be submitted to Medicare electronically, unless the provider is small or meets other exception or unusual circumstance criteria.

90.3.1 - Unusual Circumstance Waivers Subject to Provider Self-Assessment

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

The following circumstances always meet the criteria for waiver. Providers that experience one of the following "unusual circumstances" are automatically waived from the electronic claim submission requirement for either the indicated claim type or the period when an "unusual situation" exists. A provider is to self-assess when one of these circumstances applies, rather than apply for contractor or CMS waiver approval. A provider may submit claims to Medicare on paper or via other non-electronic means when one of these circumstances applies. A provider is not expected to prenotify their Medicare contractor(s) that one of the circumstances applies as a condition of submission of non-electronic claims.

1. Dental claims—Medicare does not provide dental benefits. Medicare does cover certain injuries of the mouth that may be treated by dentists, but those injury treatments are covered as medical benefits. Less than .01 percent of Medicare expenditures were for oral and maxillofacial surgery costs in 2002. The X12 837 professional implementation guide standard for submission of medical claims requires submission of certain data not traditionally reported in a dental claim but which is needed by payers to adjudicate medical claims. As result, Medicare contractors have not implemented the dental claim standard adopted for national use under HIPAA. Due to the small number of claims they would ever send to Medicare, most dentists have not found it cost effective to invest in software they could use to submit medical claims to Medicare electronically. For these reasons, dentists will not be required to submit claims to Medicare electronically.

2. Disruption in electricity or phone/communication services--In the event of a major storm or other disaster outside of a provider's control, a provider could lose the ability to use personal computers, or transmit data electronically. If such a disruption is expected to last more than 2 business days, all of the affected providers are automatically waived from the electronic submission requirement for the duration of the disruption. If duration is expected to be 2 business days or less, providers should simply hold claims for submission when power and/or communication are restored.

3. A provider is not small based on FTEs, but submits fewer than 10 claims to Medicare per month on average (not more than 120 claims per year). This would generally apply to a provider that rarely deals with Medicare beneficiaries.

4. Non-Medicare Managed Care Organizations that are able to bill Medicare for copayments may continue to submit those claims on paper. These claims are not processable by the MSPPay module and must be manually adjudicated by Medicare contractors.

5. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg but a combination of factors necessitates use of oxygen. Completion of these data elements as required in the 837-P version 4010A1 implementation guide is an assertion that the required condition for inclusion of these data elements is met. Non-completion of these data elements, however, cannot be interpreted as a statement that the required condition for inclusion of these data elements is not met. There is no means to answer "no," enter the actual oxygen saturation rate, or the arterial PO_2 measurement but not each of these conditions needs to be met for a patient to qualify for oxygen therapy. The X12 work group responsible for development of the version 4010A1 implementation guide recognizes that this is a deficiency in this implementation guide. This will be corrected in a later version of that implementation guide, but in the interim, covered entities are bound by the existing version 4010A1 requirements. As result, CMS will permit claims that meet this situation to be submitted on paper.

90.3.2 - Unusual Circumstance Waivers Subject to Medicare Contractor Approval

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

NOTE: The information in this subsection applied in FY 2004, but not for later fiscal years due to the elapsed time since the effective date (October 2003) of the ASCA electronic claim submission requirement. Providers, vendors and clearinghouses would have had more than adequate time to complete necessary systems changes prior to initiation of enforcement (Reviews by Medicare contractors and there should not be any continuing need for temporary waivers of the type listed in this section. The information is being retained here for historical reference purposes only.

Medicare contractors (carriers, DMERCs and FIs could at their discretion approve a single waiver for up to 90 days after the date of the decision notice for a provider if the contractor considered there to be “good cause” that prevented a provider from submitting claims electronically for a temporary period. “Good cause” applied if a provider made good faith efforts to submit claims electronically, but due to testing difficulties, or a similar short-term problem that the provider made reasonable efforts to rectify, the provider was not initially able to submit all affected claims electronically effective October 16, 2003.

Since these waivers could have been for less than 90 days, and contractors might have preferred to insert the basis for the waiver in the letter, Medicare contractors were to use a locally produced letter to notify providers when short-term waivers were approved for this reason. As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision were to have been addressed to the organizational name of a provider and not to an individual (whether a sole practitioner, employee or an owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or used to obtain an EIN from the IRS.

In the event that a provider cited an inability to submit certain primary or secondary claims to Medicare electronically as a result of the inability of their commercial software to submit HIPAA-compliant claims, Medicare contractors were allowed to approve a single waiver for up to 180 days after the date of the decision notice to allow adequate time for the provider to obtain and install an upgrade from their vendor, or to transition to software from another vendor that could submit these claims electronically and compliantly. Medicare contractors were to use a locally produced letter to notify providers when short-term waivers were approved for this reason.

If the contractor determined an ”unusual circumstance” applied, and an initial provider waiver of 90/180-days or less as described above was not involved, CMS approval was required. The request and the contractor’s recommendation were to have been forwarded to the Division of Data Interchange Standards/BSOG/OIS at Mail Stop N2-13-16, 7500 Security Blvd., Baltimore MD 21244 for (Review and issuance of the decision. The contractor was to have been copied on the decision notice issued to the requestor. If the contractor did not consider an “unusual circumstance” to be met, the contractor was to issue a form letter (Exhibit B).

90.3.3 - Unusual Circumstance Waivers Subject to Contractor Evaluation and CMS Decision

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

A provider may submit a waiver request to their Medicare contractor claiming other types of “unusual circumstances” outside of their control prevent submission of electronic claims. It is the responsibility of the provider to submit documentation appropriate to establish the validity of a waiver request in this situation. Requests received without documentation to fully explain and justify why enforcement of the requirement would be

against equity and good conscience in these cases will be denied. If the Medicare contractor agrees that the waiver request has merit, the request must be forwarded to the Division of Data Interchange Standards/BSOG/OIS at Mail Stop N2-13-16, 7500 Security Blvd., Baltimore MD 21244 for review and issuance of the decision. The contractor must forward an explanation as to why contractor staff recommends CMS approval to DDIS with the waiver request. The contractor will be copied on the decision notice DDIS issues to the requestor.

If the contractor does not consider an "unusual circumstance" to be met, and does not recommend DDIS approval, the contractor must issue a form letter (Exhibit B). As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision must be addressed to the organizational name of a provider and not to an individual (whether a sole practitioner, employee, or an owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or that is used to obtain an EIN.

"Unusual Circumstances" that Require CMS Review:

1. Provider alleges that the claim transaction implementation guides adopted under HIPAA do not support electronic submission of all data required for claim adjudication. (If a waiver is approved in this case, it will apply only to the specific claim type(s) affected by the IG deficiency.)

NOTE: A provider cannot be prohibited from submitting an electronic claim for which there is a paper attachment. The X12N 837 IG contains information for provider use of the PWK segment to alert a Medicare contractor that attachment information is being separately submitted. Some Medicare contractors had issued instructions regarding use of the X12 837 NTE segment to report attachment information in lieu of PWK. Submitters of claims for which there are attachments essential for adjudication must comply with the X12 attachment reporting requirements issued by their Medicare contractor for the immediate future. System changes will be made for contractor use of PWK in conjunction with implementation of the attachment standard which is scheduled for future adoption as a HIPAA standard. NCPDP claims should not have attachments.

Medicare contractors are required to accept claims electronically for reassociation with attachments submitted separately on paper or via other means such as fax when supported by individual contractors. Medicare contractors must include the process for submission of claims when there are attachments in a newsletter article and on their Web site with other applicable information concerning the ASCA requirement that Medicare claims be submitted electronically.

This attachment requirement does not apply to submission of paper EOBs or RAs for electronic claims when Medicare is secondary. See #3 in subsection 90.2 for further information.

2. A provider is not small, but all those employed by the provider have documented disabilities that would prevent their use of a personal computer for electronic submission of claims. In this case, the documentation that establishes the disability of those staff

members would need to be issued by providers other than the provider requesting the waiver and would need to be submitted for review.

3. Any other unusual situation that is documented by a provider to establish that enforcement of the electronic claim submission requirement would be against equity and good conscience. The provider must submit a waiver request to their Medicare contractor for evaluation by that contractor, and if approved at that level, for subsequent review by CMS.

In the event other situations are identified for which a requirement for electronic filing would always be considered against equity and good conscience, those situations will be added to the self-assessment list.

90.4 – Electronic and Paper Claims Implications of Mandatory Electronic Submission

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Claims providers submit via a DDE screen maintained by a Medicare shared system or transmitted to a Medicare contractor using the free/low cost claims software issued by Medicare are considered electronic. When enforcing the electronic claim submission requirement, CMS will take into account those limited situations where a provider submitted paper claims because the free billing software they were issued may have been temporarily unable to accommodate submission of a secondary or other particular type of claim.

Medicare contractors are prohibited from requiring submission of paper claims in any situations on or after October 16, 2003, except as specifically permitted by CMS.

Medicare carriers, DMERCs, and FIs are to assume for processing purposes that claims submitted by a provider on paper October 16, 2003, and later are submitted by providers that are small or that do meet exception criteria, barring information received from other sources to the contrary. Submission of a paper claim October 16, 2003, or later will be considered an attestation by a provider that waiver criteria are met at the time of submission.

90.5 – Enforcement

(Rev. 831, Issued: 02-02-06; Effective: 07-01-06; Implementation: 07-03-06)

Enforcement will be conducted on a post-payment basis. Shared system maintainers will prepare quarterly reports for the contractors that list each provider's name, provider number, address, number of paper claims received under each provider number, percentage of paper claims to total claims for each provider, and the period being reported, e.g., claims processed July 1, 2005 – September 30, 2005. The data in the reports must be arrayed in descending order with those providers receiving the highest number of paper claims at the beginning of the report. These reports must be available by the end of the month following completion of a calendar quarter, e.g., on October 31

for July 1-September 30. Medicare contractors will obtain and analyze these reports by the end of the following month and select providers submitting the highest numbers of paper claims for review.

Medicare carriers, DMERCs, and FIs will be issued separate funding under budget activity 17004 for enforcement of the ASCA electronic claim submission requirement. Each contractor will be notified of the number of ASCA paper biller reviews their staff will be expected to conduct when the annual funding is issued for these reviews. Information on the number of reviews to be conducted and the identity of the providers selected for review will not be made public.

Contractors are to request information from the selected providers to establish that they meet criteria for submission of paper claims. See exhibit C for the request letter. If no response is received within 45 calendar days (30 calendar days with time allotted for initial postal delivery, review by the provider, and return postal delivery; see exhibit D for the letter), or if a provider's response does not establish eligibility to submit paper claims (see Exhibit E for the letter), the contractor will notify the provider by mail that:

1. Any paper claims received more than 90 calendar days after the date of the initial request letter will be denied and not paid by Medicare;

2. Free billing software is available for provider use (contractor must furnish contact information for the provider to obtain further information);

3. Commercial billing software is also available on the open market for submission of Medicare claims and that clearinghouses and other vendors offer electronic claims services commercially (contractor must insert reference to information available as discussed in section 60.8); and

4. A Medicare decision that a provider is ineligible to submit paper claims is not subject to appeal.

The contractor must enter the determination to the system to assure that paper claims from the provider are denied effective with the 91st calendar day after issuance of the letter. *Contractors have authority to delay this determination until the 121st day if the provider indicates all changes needed to submit their claims electronically will be completed by no later than the 121st day, and based on prior experience with this provider, the contractor has confidence that the provider will comply by that date. Contractors must contact CMS Division of Data Interchange Standards (DDIS) in OIS/BSOG for permission to approve any extension beyond the 121st day.* If review of the response determines that the provider is eligible to submit paper claims to Medicare, notify the provider by mail of that determination (see exhibit F for a sample letter).

If the provider subsequently submits documentation to establish that they actually met criteria for submission of paper claims, effective with that 91st day, the contractor must remove the determination from the system to assure that future paper claims from the provider are not denied. The contractors must notify the provider by mail (see Exhibit F

for a sample letter) of that determination. The contractor will not reprocess those paper claims denied during the interim unless those claims are resubmitted by the provider.

If a provider submits documentation to establish eligibility to submit paper claims but that eligibility is effective after the 91st day, and the provider resubmits denied claims, do not approve any claims that contain dates of service that fall between the 91st day and the date when the provider became eligible to submit claims on paper.

Medicare contractors are not to maintain a provider FTE database, or establish a database of waived providers, unless an "unusual situation" waiver decision is made (see §90.3.2 and §90.3.3), or an enforcement review is conducted. Each contractor will indefinitely maintain a local Excel spreadsheet of "unusual situation" waivers, with column headings for the name, address, provider number, whether the "unusual circumstance" waiver was approved or denied, the termination date for an approval (if applicable), and the unusual circumstance identified in the request. Exclude locally approved 90/180-day waivers from this list. Contractors are also to maintain an Excel spreadsheet with column headings for provider name, provider number, address, date of enforcement review determination of each provider reviewed, whether continued submission of paper claims is approved or denied, the exception/waiver condition claimed by the provider, and if denied, date rejection of paper claims to begin. Contractors must be able to submit these reports to CMS when requested. Contractors shall not review the same provider again for at least two years if the provider justified submission of paper claims to Medicare, and that justification is expected to be in force for at least two years.

NOTE: Some ASCA exceptions apply to individual claim types only, or to submission of paper claims for temporary periods. CMS does not expect that the number of paper claims submitted under those limited range exceptions should be high enough to trigger review of providers allowed to submit claims of that type on paper for an entire quarter or part of a quarter, as long as the balance of the claims submitted by those providers for the quarter are electronic. If a contractor is able to determine that a provider would not have met the criteria for selection for an ASCA review if the number of claims permitted to be submitted on paper under a specific exception in §§90.2 or 90.3 were subtracted from the total number of paper claims submitted by the provider for the quarter, the contractor can curtail the review of that provider. In this case, identifying information on the provider, the reason the provider's review was curtailed, and the date of that decision must be recorded in the Excel spreadsheet. Contractors must check the Excel spreadsheet when determining whether any provider tentatively selected for review after the first review quarter has a prior review history which could result in exclusion of that provider from re-review at that time or which could contribute to the current review. If there was a prior review that was curtailed, a contractor must determine if the same exception should still apply to the provider (in which case, the provider should not be reviewed), or if that exception should have expired before the quarter for which now selected for review (in which case, the provider must be reviewed).

The group code CO (provider financial liability) is to be used with reason code 96 (non-covered charges), remark code M117 (Not covered unless submitted by electronic claim), and remark code MA44 (No appeal rights. Adjudicative decision based on law) for the entire billed amount in the remittance advice sent to the provider for these claims. When a provider's claim is denied for this reason, the beneficiary MSN must contain message 9.9, "This service is not covered unless supplier/provider files an electronic media claim." See Chapter 21 for further MSN information. Although it may be advisable for a beneficiary to change his/her provider when a provider refuses to bill Medicare electronically and does not qualify for an exception for paper billing, this may not be a reasonable option for some beneficiaries. The "Medicare & You" Handbook (section 7, 2005) directs beneficiaries to contact their provider and request the claim be resubmitted electronically if they receive this denial message in an MSN. If the provider refuses, the beneficiary is then directed to contact 1-800-Medicare for further possible action or guidance.

If a provider is selected for an ASCA enforcement review that is also undergoing a fraud or abuse investigation, a carrier, DMERC or FI has discretion to exclude that provider from the ASCA enforcement review if it would interfere with the fraud/abuse investigation, or to combine the review with the fraud/abuse investigation. If an ASCA enforcement review is not conducted due to possible interference, and the provider is subsequently cleared of fraud or abuse, the ASCA enforcement review is to be conducted when that fraud/abuse investigation is completed.

90.6 - Provider Education

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Medicare contractors were required to include information on their provider Web site and in a newsletter by April 2004 to notify providers of/that:

1. Providers that do not qualify for a waiver as small and that do not meet any of the remaining exception or waiver criteria must submit their claims to Medicare electronically;

2. Small provider criteria and that small providers are encouraged to submit as many of their claims electronically as possible;

3. FTE definition and calculation methodology;

4. Exception criteria;

5. Unusual circumstance criteria;

6. Self-assessment requirements;

7. Process for submission of an unusual circumstance waiver;

8. Additional claims, such as certain claim types not supported by free billing software, that must continue to be submitted on paper pending any contractor or shared system modifications to enable those claims to be submitted electronically;

9. Submission of paper claims constitutes an attestation by a provider that at least one of the paper claim exception or waiver criterion applies at the time of submission;

10. Repercussions of submitting paper claims when ineligible for submission of paper claims;

11. Post-payment monitoring to detect providers that submit unusually high numbers of paper claims for further investigation; and

12. Waiver request submitted by providers should include the providers' name, address, contact person, the reason for the waiver, why the provider considers enforcement of the electronic billing requirement to be against equity and good conscience, and any other information the contractor deems appropriate for evaluation of the waiver request.

Exhibits of Form Letters

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Exhibit A—Response to a non- "unusual circumstance" waiver request

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Date:

From: Contractor (may be preprinted on a contractor's letter masthead)

To: Organizational Name of Provider

Subject: Electronic Claim Submission Waiver Request

You recently submitted a request for waiver of the Administrative Simplification and Compliance Act (ASCA) requirement that claims be submitted electronically effective October 16, 2003 to qualify for Medicare coverage. Providers are to self-assess to determine if they meet the criteria to qualify for a waiver. A request for waiver is to be submitted to a Medicare contractor only when an "unusual circumstance," as indicated in c, d, or, e below applies. Medicare will only issue a written waiver determination if c, d, or e applies.

ASCA prohibits Medicare coverage of service and supply claims submitted to Medicare on paper, except in limited situations. Those situations are:

1. Small providers—To qualify, a provider required to submit claims to Medicare FIs must have fewer than 25 full time equivalent employees (FTEs), and a physician, practitioner, or supplier that bills a Medicare carrier must have fewer than 10 FTEs;

2. Dental Claims;

3. Participants in a Medicare demonstration project, when paper claim filing is required by that demonstration project as result of the inability of the HIPAA claim implementation guide to handle data essential to that demonstration;

4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of flu shot claims;

5. Providers that submit claims for Medicare payment after receiving payment from more than one other payer and at least one of those payers reduced their payment due to an Obligated to Accept as Payment in Full (OTAF) adjustment;

6. Providers of home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;

7. Those few claims that may be submitted by beneficiaries;

8. Providers that only furnish services outside of the United States;

9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and

10. Providers that can establish that some other "unusual circumstance" exists that precludes submission of claims electronically.

The Centers for Medicare & Medicaid Services (CMS) interprets an "unusual circumstance" to be a temporary or long-term situation outside of a provider's control that precludes submission of claims electronically and as result, it would be against equity and good conscience for CMS to require claims affected by the circumstance to be submitted electronically.

Examples of "unusual circumstances" include:

a. Limited temporary situations when a Medicare contractor's claim system would reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);

b. Providers that submit fewer than 10 claims a month to a Medicare contractor on average;

c. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

d. Entities that can demonstrate that information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

e. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that, due to conditions outside of the provider's control, it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

The request you submitted did not include information to establish that situation c, d, or e applies. You are expected to self-assess to determine if one of the other exceptions or unusual circumstances apply. If your self-assessment indicates that you do meet one of those situations, you are automatically waived from the electronic claim submission

requirement while the circumstance is in effect. Medicare contractors will monitor provider compliance on a post-payment basis.

If a provider's self-assessment does not indicate that an exception or waiver criteria apply, the provider must submit their claims to Medicare electronically. Free software can be furnished you by this office to enable you to submit claims electronically, and a number of commercial software products and services are available on the open market. Please phone (insert contractor phone number) if you would like to further discuss your options for electronic submission of claims to Medicare.

Sincerely,

Contractor Name

Exhibit B—Denial of an "unusual circumstance" waiver request

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Date:

From: Contractor Name and address (may appear on masthead)

To: Organizational Name of Provider

Subject: Request for Waiver of Electronic Claim Filing Requirement Decision

Your request for waiver of the requirement that Medicare claims be submitted electronically has been denied. The Administrative Simplification Compliance Act (ASCA) prohibits Medicare coverage of claims submitted to Medicare on paper, except in limited situations. Those situations are:

1. Small providers—To qualify, a provider required to submit claims to Medicare FIs must have fewer than 25 full-time equivalent employees (FTEs), and a physician, practitioner, or supplier that bills a Medicare carrier must have fewer than 10 FTEs;

2. Dental Claims;

3. Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;

4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of flu shot claims;

5. Providers that submit claims for Medicare payment after receiving payment from more than one other payer and at least one of those payers reduced their payment due to an Obligated to Accept as Payment in Full (OTAF) adjustment;

6. Providers of home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;

7. Those few claims that may be submitted by beneficiaries;

8. Providers that only furnish services outside of the United States;

9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and

10. Providers that can establish that an "unusual circumstance" exists that precludes submission of claims electronically.

The Centers for Medicare & Medicaid Services (CMS) interprets an "unusual circumstance" to be a temporary or long-term situation outside of a provider's control that precludes submission of claims electronically and as a result, it would be against equity and good conscience for CMS to require claims affected by the circumstance to be submitted electronically. Examples of "unusual circumstances" include:

a. Limited temporary situations when a Medicare contractor's claim system would reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);

b. Providers that submit fewer than 10 claims per month to a Medicare contractor on average;

c. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

d. Entities that can demonstrate the information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

e. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that due to conditions outside the provider's control it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

We have determined that you do not meet any of these criteria for waiver of the ASCA requirement for electronic submission of Medicare claims. ASCA did not establish an appeal process for waiver denials, but you can re-apply for an "unusual circumstance" waiver if your situation changes.

Waiver applications are only to be submitted to request a waiver if an "unusual circumstance" applies under c, d or e above. The information submitted with your waiver request did not indicate that circumstance c, d, e, or any other exception or waiver criteria apply in your case. If provider self-assessment indicates that an exception condition, other than c, d, or e is met, the provider is automatically waived from the electronic claim submission requirement and no request should be submitted to a Medicare contractor. Medicare contractors will monitor provider compliance on a post-payment basis.

Paper claims submitted to Medicare that do not meet the exception or unusual circumstance criteria do not qualify for Medicare coverage. Free software can be furnished you by this office to enable you to submit claims electronically, and a number of commercial software products and services are available on the open market. Please phone (insert contractor phone number) if you would like to further discuss your options for electronic submission of claims to Medicare.

Sincerely,

Contractor Name

Exhibit C—Request for Documentation from Provider Selected for (Review to Establish Entitlement to Submit Claims on Paper

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Date:

From: Contractor (May be preprinted on a contractor's masthead)

TO: Organizational Name of Provider

Subject: Review of Paper Claims Submission Practices

A large number of paper claims were submitted under your provider number during the last calendar quarter. Section 3 of the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions. The ASCA amendment to section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

ASCA prohibits submission of paper claims unless providers are classified as:

1. FI small providers - To qualify, a provider required to submit claims to Medicare must have fewer than 25 full-time equivalent employees (FTEs).

   Carrier small providers - To qualify, a physician, practitioner, or supplier that bills Medicare must have fewer than 10 FTEs;

2. Dentists;

3. Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;

4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of flu shot claims;

5. Providers that submit a claim for Medicare payment after the claim was processed by more than one other payer;

6. Providers of home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;

7. Those few claims that may be submitted by beneficiaries;

8. Providers that only furnish services outside of the United States;

9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and

10. Providers that can establish that an "unusual circumstance" exists that precludes submission of claims electronically.

The Centers for Medicare & Medicaid Services (CMS) interprets an "unusual circumstance" to be a temporary or long-term situation outside of a provider's control that precludes submission of claims electronically and therefore, it would be against equity and good conscience for CMS to require claims affected by the circumstance to be submitted electronically. Examples of "unusual circumstances" include:

a. Limited temporary situations when a Medicare contractor's claim system would reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);

b. Providers that submit fewer than 10 claims per month to a Medicare contractor on average;

c. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

d. Entities that can demonstrate the information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

e. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that due to conditions outside the provider's control it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

If you intend to continue to submit paper claims, please respond within 30 calendar days of the date of this letter to indicate which of the above situations is your basis for continuing submission of paper claims to Medicare. Include with your response, evidence to establish that you qualify for waiver of the electronic filing requirement under that situation. For instance, if you are a small provider, evidence might consist of copies of payroll records for all of your employees for (specify the start and end dates of the calendar quarter for which the review is being conducted) that list the number of hours each worked during that quarter. If you are a dentist, evidence might be a copy of your license.

If you are in a Medicare demonstration project, evidence might be a copy of your notification of acceptance into that demonstration. If you are a mass immunizer, evidence might be a schedule of immunization locations that indicates the types of immunizations furnished. If you experienced an extended disruption in communication or electrical services, evidence might consist of a copy of a newspaper clipping addressing the outage. If the paper claims were submitted because this office notified you of a system problem preventing submission of these claims electronically, please note that in your response.

If your continuing submission of paper claims is the result of medical restrictions that prevent your staff from submitting electronic claims, evidence would consist of

documentation from providers other than yourself to substantiate the medical conditions. If you obtained an unusual circumstance waiver, evidence would be a copy of your notification to that effect from this office or the Centers for Medicare & Medicaid Services.

In some of these situations, permission to submit paper claims applies only to a specific claim type, e.g., flu shots, for a temporary period. In those cases, only those claims can be submitted on paper. Providers that received waivers for a specific claim type or for a specific period are still required to submit other claims electronically unless they meet another criterium, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, dentist, or otherwise qualify for a waiver under a situation that applies to all of their claims.

If you cannot provide acceptable evidence to substantiate that you are eligible under the law to continue to submit paper claims to Medicare, we will begin to deny all paper claims you submit to us effective with the 91st calendar day after the date of this notice. This decision cannot be appealed.

If in retrospect, you realize that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. *See (Contractor is to enter the URL) for further information on enrollment for use of EDI, use of free billing software and other EDI information).* There is also commercial billing software, billing agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs.

Sincerely,

Contractor Name

Exhibit D—Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of non-response to that letter

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Date:

From: Contractor (may be preprinted on a contractor's masthead)

To: Organizational Name of Provider

Subject: (Review of Paper Claims Submission Practices

Section 3 of the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions. The ASCA amendment to section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

Our records indicate that you are submitting paper claims to Medicare and did not respond to our initial letter requesting justification to establish that you qualify for submission of paper claims to Medicare. Nor do we have information available to us that would substantiate that you meet any of the limited exceptions that would permit you to legally submit paper claims to Medicare.

Consequently, as noted in the initial letter as well as in information issued providers when this requirement was put into effect, any Medicare paper claims you submit more than 90 calendar days from the date of the initial letter requesting evidence to substantiate your right to submit paper claims will be denied by Medicare. You may not appeal this decision.

If you did not respond because you realized that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. *See (Contractor is to enter the URL) for further information on enrollment for use of EDI, use of free billing software and other EDI information).* There is also commercial billing software, billing

agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs.

Sincerely,

Contractor Name

Exhibit E—Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of determination that the provider is not eligible to submit paper claims.

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Date:

From: Contractor (may be preprinted on a contractor's masthead)
To: Organizational Name of Provider
Subject: (Review of Paper Claims Submission Practices

Section 3 of the Administrative Simplification Compliance Act, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions. The ASCA amendment to section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Entities determined to be in violation of the statute or this rule may be subject to claim rejections, overpayment recoveries, and applicable interest on overpayments.

We have (Reviewed your response to our initial letter requesting you to submit evidence to substantiate that you qualify for submission of paper claims under one of the exception criteria listed in that letter. Upon (Review, we have determined that you do not meet the paper claims waiver/exception criteria because (contractor must insert the reason). This determination is not subject to appeal.

Consequently, any Medicare paper claims you submit on or after the 91st calendar day from the date of the initial letter requesting that evidence will be denied by Medicare.

You have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. *See (Contractor is to enter the URL) for further information on enrollment for use of EDI, use of free billing software and other EDI information).* There is also commercial billing software, billing agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs.

Sincerely,

Contractor Name

Exhibit F—Notice that determination reached that the provider is eligible to submit paper claims.

Date:

From: Contractor (may be preprinted on a contractor's masthead)
To: Organizational Name of Provider
Subject: (Review of Paper Claims Submission Practices

Thank you for your response to our previous letter regarding the prohibition against the submission of paper claims to Medicare. Based on that information, we agree that you meet one or more exception criteria to the requirements in section 3 of the Administrative Simplification Compliance Act, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, that require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions.

If your situation changes to the point where you no longer meet criteria, you will be required to begin submission of your claims electronically within 90 calendar days from that change in your status.

Although you are not required to submit claims electronically at the present time, you are encouraged to do so. Please contact us at (insert EDI contact information) if you would like to discuss use of the Medicare free billing software or other alternatives for submission of claims electronically.

Sincerely,

Contractor Name